2018 CPC+ IMPLEMENTATION GUIDE: GUIDING PRINCIPLES AND REPORTING

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Introduction

The *2018 CPC+ Implementation Guide: Guiding Principles and Reporting* (referred to hereafter as the Guide) orients you to our work together in Program Year (PY) 2018, provides guidance on how you can transform your practice and report on your care delivery, and describes resources to support your efforts in the coming year. This Guide provides 2018 Starters with information that is foundational to beginning your work in CPC+. 2017 Starters will find strategies you can use to continue to build upon your care redesign to date. Whether you are just getting started in CPC+ or already advancing your improvements in care, you can use the high-impact change concepts and tactics described in the Guide to test changes you make in your practice, guided by clinical-, payer-, and patient-reported data.

CPC+ Logic Model

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

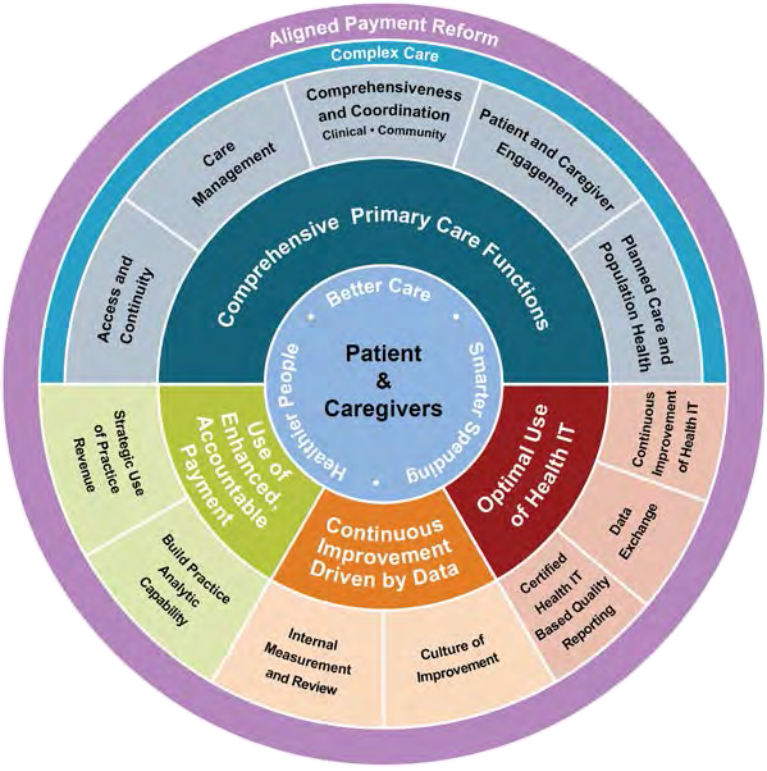


Figure 1: Driver Diagram

This Guide provides general guiding principles, tactical suggestions, and resources to support your work in CPC+. This work involves building capability within your practice to meet the ongoing needs of your patient population and documenting that work along the way so that we can understand your progress and make changes to CPC+ to reflect practice innovations.

How to Use This Guide

This Guide is organized in four sections—Care Delivery, Practice Reporting, Quality Measurement and Reporting, and Payment and Composition Policies—and includes appendices with additional resources.

Section I: Care Delivery

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

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

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

- **Defining the change.** This subsection describes the change concept and why the change concept is important to your practice. *Change concepts* are foundational ideas that are core to making changes that lead to improvement. *Change tactics* are specific examples of how your practice can implement key change concepts. Your practice is encouraged to implement high-value change tactics that are tied to the Comprehensive Primary Care Functions. These change tactics will guide your practice through the work of practice change to achieve and innovate on the CPC+ care delivery requirements. The change tactics for each change concept are highlighted in blue callout boxes.
- **Care delivery requirements.** Care delivery requirements for Program Year 1 (for 2018 Starters) and Program Year 2 (for 2017 Starters) tied to a function or driver are highlighted in green callout boxes. You can use the "roadmap" in Appendix C as a guide for pacing change and tracking your practice's progress towards achieving your goals in CPC+. The roadmap illustrates the suggested high-level changes that may lead to the enhanced capabilities required in subsequent years.

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

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

- **FAQs.** Purple callout boxes include answers to questions that were frequently asked by 2017 Starters in Program Year 1.

- **Key Insights.** Teal callout boxes describe important elements or actions critical to achieving practice transformation based on the surrounding content.

Section II: Practice Reporting

This section includes all questions, reporting frequencies, definitions, and other notes to help you understand your practice's reporting. These questions prepare your practice to gather the information that you will report quarterly. This information can also serve as a useful assessment tool for you to track your practice transformation progress and to identify gaps and areas for improvement over the upcoming year. You can use the Care Delivery Reporting Guide as a worksheet for care delivery reporting for PY 2018, as well as the resources provided in the Financial Reporting Overview. The information you collect and provide in your financial report is incredibly valuable as it allows you to track your CPC+ revenue and expenditures, and to identify what portion of your practice's overall budget goes toward "CPC+ work." It also allows us to understand what resources are needed to support practice transformation through CPC+, and measure the level of additional revenue you receive from CMS and payer partners.

Section III: Quality Measurement and Reporting

The Quality Measurement and Reporting section highlights important resources, timelines, and steps for quality measurement and quality reporting for PY 2018.

Data and measurement are critical components to CPC+. CMS will assess cost and quality annually using electronic clinical quality measures (eCQMs) reported at the practice-level, utilization measures based on the claims for your attributed patients, and a patient experience of care survey conducted by and paid for by CMS.[2] If you are a Track 2 practice, you will also participate in the development of patient-reported, outcome-based performance measures relevant to primary care.

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

[2] CMS. Consumer Assessment of Healthcare Providers & Systems (CAHPS). (2017, June 20). Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/

Section IV: Payment and Composition Policies

This section guides you through key CPC+ program policies, including those related to CPC+ payments and practice composition.

CPC+ contains three types of payments, which are described in this section, as well as an overview of beneficiary attribution and payment methodologies.

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

Appendices

The appendices include additional resources that can support your work in CPC+. This section includes a list of key resources that you will refer to as you transform your practice through CPC+, as well as templates, guidelines, videos, and checklists. This section also contains a wealth of information about health IT, including the requirements, definitions, and policies for your reference. Finally, the appendices provide information about how you can access the CPC+ Practice Portal and CPC+ Connect, a collaboration and knowledge sharing platform.

You are strongly encouraged to use CPC+ Connect as a primary source of insights and tools from the CPC+ community. **CPC+ Connect is a web-based platform designed for you and your practice staff to share ideas, best practices, and resources with other CPC+ participants.** The website's easy-to-use features are designed to support you in your work toward the CPC+ care delivery requirements, as well as collaboration around health IT functionality, quality measurement, and other aspects of care delivery.

The CPC+ Connect Library includes over 1,000 resources, including official CPC+ policies and guidelines, recordings and slides from all CPC+ learning events, on-demand instructional videos on reporting and using CPC+ tools (e.g., the CPC+ Practice Portal, CPC+ Connect), tools and templates developed and shared by CPC+ participating practices, as well as relevant practice transformation and quality improvement resources developed by other organizations.

All resources included in this Guide are accessible through the CPC+ Connect Library. **Please note that you must be logged in to CPC+ Connect before clicking on the links to access the resources.** If you do not have access to CPC+ Connect, please follow the steps in Appendix H, Accessing CPC+ Connect.

Section I: Care Delivery

Driver 1: Five Comprehensive Primary Care Functions

Introduction

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

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

Care Management. Care management for high-risk, high-need patients is a hallmark of comprehensive primary care. Every practice participating in CPC+ must quickly build or augment a robust care management capacity; this is one of the most critical changes you will make as part of the model. Practices focus their care management resources on two cohorts of patients who are likely to benefit from this intensive resource: patients with complex medical, behavioral, and/or social needs requiring proactive, relationship-based (longitudinal) care management and those otherwise stable patients who require short-term, problem-oriented (episodic) care management after a temporary change in status, like a hospitalization.

To identify these two cohorts of patients, your practice can use a systematic approach to risk stratify the entire practice population, identifying those patients at increased risk and then a subset of those most likely to benefit from targeted, proactive, relationship-based (longitudinal) care management. You can use event triggers (e.g., hospital discharges and other transition of care, new diagnosis of major illness) to identify patients for episodic (short-term) care management, regardless of risk status.

Data from CMS and other payers, as well as from health IT systems—complemented by clinical judgment and your care team's knowledge of each patient—will guide your risk stratification process. Care management is targeted; fully integrated into the primary care practice; and guided by a patient-centered plan, focusing on what the patient needs to meet his or her health goals.

Comprehensiveness and Coordination. *Comprehensiveness* in the primary care setting refers to the capability to address as many of your patient population's medical, behavioral, and health-related social needs through your practice as is feasible. *Coordination* refers to the work of bridging the gaps between systems of care for all patients (not just those in care management). This work adds both breadth and depth to your practice's delivery of primary

care services; builds on the element of the long-term, trusting relationship that are at the heart of effective primary care; and is associated with overall lower utilization and costs, less fragmented care, and better health outcomes. Comprehensiveness and coordination are essential to the care of persons with complex medical conditions and social needs, and also key reasons many primary care practitioners entered the field.

CPC+ focuses on an important set of evidence-based strategies for better meeting the needs of patients with complex medical, behavioral, and social needs: 1) integration of behavioral health care into primary care; 2) intensive management of complex medication regimens; 3) identification of health-related social needs and referral to and coordination with community-based resources to address those needs; and 4) coordination of care and exchange of information with emergency departments, hospitals, and specialists.

As a CPC+ practice, you will act as the hub of care for your patient population, using data to identify population-specific needs and building capability within your practice and through referral to address those needs.

Patient and Caregiver Engagement. To achieve optimal care and health outcomes, patients and caregivers need to be engaged in the management of their own care and in the design and improvement of care delivery. Your practice can use a variety of strategies to gain insight into the patient and caregiver perspective on the organization and delivery of care, including Patient and Family Advisory Councils (PFACs), office-based surveys, and focus groups.

Your practice can support self-management of care through condition-specific training and tools, by integrating tools and strategies that apply across conditions into usual care, and by incorporating shared decision making strategies into care of selected conditions.

Values-based conversations about advance care planning can help ensure patients get the care they want when they are most vulnerable. These conversations are especially valuable for frail and medically complex patients. Documentation of these conversations is also important.

Planned Care and Population Health. Organizing your practice into effective care teams that have the data they need to manage their panel of patients is central to the delivery of effective comprehensive primary care. Care teams must also have protected time and space to implement strategies to improve care and outcomes. By using evidence-based protocols, registries, the registry functionality of your practice's electronic health record (EHR), as well as reminders and outreach, your practice will deliver timely and appropriate preventive care, and provide consistent evidence-based management of chronic conditions for your entire patient population. Your practice's measurement of clinically relevant practice-level and panel-level data will guide your testing and implementation of strategies to improve care and outcomes.

Each of the five Comprehensive Primary Care Functions is described in more detail in the 2018 CPC+ Practice Care Delivery Roadmap and Goals, which includes change concepts and change tactics your practice can use to transform its operations and care delivery. The CPC+ 2018 Care Delivery Requirements provides CPC+ requirements for each of the five Comprehensive Primary Care Functions.

Function 1: Access and Continuity

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

a. Health IT allows practice to assign each patient to a care team or practitioner, and to sort and review the patients by assignment.
b. The assigned provider should be visible in the patient record to members of the care team.

In CPC+, your practice will enhance a core function of primary care: achieving balance between timely access and continuity of care for your patients.

Access refers to the availability of health services when patients need and want them. *Continuity* refers to the creation of long-term, trusting relationships between patients and practitioners to enable effective provision of care. These relationships are hallmarks of primary care. Continuity in relationships and in knowledge of patients and their caregivers provides perspective and context throughout all stages of life, including end-of-life care.[3]

Evidence suggests that improving access and continuity increases the likelihood that patients get the right care at the right time, potentially avoiding costly urgent and emergent care.[4] Research also indicates that improving access and continuity is accomplished through effectively aligning supply and demand (e.g., no backlog of appointments, no delay between when demand is initiated and when the service is delivered).[5]

Many factors will influence supply and demand for patient care (e.g., seasonal changes, days and times of the week, referrals) and it is important to understand those factors so you can begin to predict needs for services like appointments, advice, and medication refills. The best way to start to understand supply and demand in your practice is to measure it. After you have measured and compared demand and supply in your practice, you can begin to bring the two into better balance.

To learn more about how supply and demand can affect access, see the Institute for Healthcare Improvement (IHI) guidelines on measuring and understanding supply and demand.

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

- Empanel all patients to a practitioner and/or care team.
- Ensure timely access to care
- Optimize continuity with the practitioner and/or care team

[3] Patient-Centered Primary Care Collaborative (2017, January 11). Shared Principles of Primary Care. Retrieved from https://www.pcpcc.org/about/shared-principles
[4] Office of Disease Prevention and Health Promotion. (2017, December 7). Access to Health Services. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services
[5] Institute for Healthcare Improvement (IHI). (n.d.) Measure and Understand Supply and Demand. Retrieved from http://www.ihi.org/resources/Pages/Changes/MeasureandUnderstandSupplyandDemand.aspx

Function 1 Requirements

Program Year 1 (2018 Starters)

a. Achieve and maintain at least 95% empanelment to practitioner and/or care teams.
b. Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR.
c. Organize care by practice-identified teams responsible for a specific, identifiable panel of patients to optimize continuity.
d. **Track 2:** Regularly offer at least one alternative to traditional office visits to increase access to the care team and clinicians in a way that best meets the needs of the population, such as e-visits, phone visits, group visits, home visits, alternate location visits (e.g., senior centers, assisted living facilities), and/or expanded hours (e.g., early mornings, evenings, weekends).

Program Year 2 (2017 Starters)

a. Maintain at least 95% empanelment to practitioner and/or care teams.
b. Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR.
c. Measure continuity of care for empaneled patients by practitioners and/or care teams in the practice.
d. **Track 2:** Regularly deliver care in at least one way that is an alternative to traditional office visit-based care, meets the needs of your patient population, and increases access to the care team/practitioner, such as e-visits, phone visits, group visits, home visits, and/or alternate location visits (e.g., senior centers, assisted living facilities).

Empanel all patients to a practitioner and/or care team

Defining the change

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

Empanelment is a series of processes that assign each active patient to a practitioner and/or care team, with consideration of patient and caregiver preferences. Empanelment will allow your practice to build effective and responsive care teams to optimize patient care, and to address the preventive, chronic, and acute care needs of all patients.[6] The central goal of empanelment is to enhance relationships between patients and their practitioners and/or care teams, while shifting the team's focus towards the health of a defined panel of patients.[7]

Empanelment is not just about assignments within the EHR or lists within a registry. It is an active, continually updated process meant to ensure that patients know who knows them and their needs. For practitioners, empanelment enables you to provide proactive care to all

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

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

members of a panel, not just those who happen to come for in-person visits. A key tactic related to empanelment is outlined in the Change Tactic table above.

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

FAQ: Can I refine my active patient criteria?

Answer: There are many ways to define "active patients" and you should determine which criteria are best for your practice operations. You may adjust your active lookback period so your panel information is accurate. For example, you may choose to only include patients who had a certain number of touches with your practice or who still live in the area, and may exclude deceased patients, if you can track these in your current systems. Your health IT is vital to storing and tracking your active patient population.

Link/empanel each patient to a practitioner and/or care team. Your practice should assign each active patient to a practitioner and/or care team, then confirm the assignment with the patient and the practitioner and/or care team.

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

Key Insights

Benefits of Empanelment:

- Formalizes a continuous relationship between patients and practitioner-led care team
- Provides a population denominator for important practice measures, including quality of care
- Allows you to identify care gaps and proactively reach out to patients who have not been seen or contacted in a while

FAQ: Should we empanel only our Medicare patients or all our patients?

Answer: CPC+ is a population-wide transformation in which you are making significant changes in your care delivery for all your patients, regardless of insurer, coverage status, or CPC+ attribution. Thus, you should empanel all your identified active patients.

The empanelment process can help your practice answer specific questions about the patients you care for. By empaneling your practice's patient population, you can answer questions like the following:[8]

- Which patients are active and inactive in our panel?
- What percent of our active patients are assigned to specific practitioners and/or care teams?
- Are we seeing patients who are not our primary care patients (e.g., patients referred to us for specialty consultation or presenting for urgent care, but who receive primary care elsewhere) and are we able to exclude them from our empanelment process?

Now that you have empaneled your patients, your practice should establish a process to regularly revisit and "right size" each panel based on patient needs and preferences, as well as practitioner/care team preferences, availability, and skills (e.g., practitioners who have more experience and training to treat patients with multiple complex or specific health conditions might have fewer empaneled patients than a practitioner who prefers to see less complex patients) to ensure the accuracy of patients empaneled to each practitioner and or care team.

It is critical that once you have an accurate list of empaneled patients appropriate for the size and capacity of the team, you establish mechanisms to reach out to those patients who have not been seen or contacted in a while. In particular, you should proactively engage with patients who have chronic diseases or known preventive gaps in care to close those gaps. It is only through a continual empanelment process that your practice can know who might be falling through the cracks, and who might benefit from targeted outreach, instead of waiting for patients to get sick or reach out on their own.

Ensure timely access to care

Defining the change

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

[8] Grumbach, K. & Olayiwola, J. N. (2015). Patient Empanelment: The Importance of Understanding Who Is at Home in the Medical Home. *The Journal of the American Board of Family Medicine*. Retrieved from: http://www.jabfm.org/content/28/2/170.full

Timely access can be defined as the health care system's ability to provide health care quickly after a need arises (e.g., availability of appointment and care when it is needed) and time spent waiting to be seen by the practitioner.[9]

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

Change Tactics	
1.	Provide 24/7 access, guided by the medical record, to the practitioner and/or care team for advice and information to guide urgent and emergent care.
2.	Use a patient portal and secure messaging to provide access to health information.
3.	Provide office hours in early mornings, evenings, and weekends with access to the patient medical record.
4.	Provide same-day or next-day access to the patient's own practitioner and/or care team for urgent care or transition management.
5.	Use alternatives for care outside of the traditional office visit to increase access to the care team and the practitioner, such as e-visits, phone visits, group visits, home visits, and visits in alternate locations (e.g., senior centers, assisted living centers) captured in the medical record.

As you begin to implement new approaches to improve patient access, especially through using alternatives for care outside of the traditional office visit, it will be important to identify targeted populations of patients who will benefit most from new care modalities, and to establish a set of metrics that will give your practice insight into how these strategies are bringing the demand for care and the supply of services into better balance.

Provide 24/7 access to care. Your practice will provide patients real-time access to their assigned practitioner and/or a care team member. Patients' medical records should guide real-time access, 24 hours a day and 7 days a week. As patient needs often occur outside of traditional office hours, your practice should create pathways for continuous, reliable access.

You can accomplish 24/7 access in many ways, including the use of an on-call practitioner or care team member, cross coverage by another practitioner external to your practice, and/or the use of protocol-driven nurse lines. Regardless of your practice's approach, the care team member providing 24/7 coverage must be a licensed medical practitioner—a Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO), Nurse Practitioner (NP), Registered Nurse (RN), or Physician Assistant (PA)—who has access to the EHR. Access to the EHR gives the practitioner vital information from the medical record that may decrease over-utilization of costly emergency department (ED) services and duplicative testing.

[9] Office of Disease Prevention and Health Promotion. (n.d.) Access to Health Services. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services

Educating your patients about how to access your practice after hours is an important aspect of improving 24/7 access to care. CPC+ practices have reported that even though they have clear policies describing their 24/7 access, they often find their patients are still seeking care in EDs and urgent care centers without first contacting their practitioner or care team. Many practices have described successful collaboration with their PFAC as contributing to their understanding of the root causes for patients accessing the ED and urgent care center, and that this understanding informs their development of patient education materials on how to access after-hours care.

Learn how a CPC+ practice, Glenwood Medical Associates, is testing a "Call Us First" program to decrease ED visits by encouraging patients to utilize its extended services.

As you move forward in CPC+, continue to monitor your ED and urgent care utilization data and identify potential needs for new patient education opportunities.

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

Key Insights

Considerations for your practice:

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

- How many same-day or next-day appointments can we offer patients?
- What percent of our patients send secure messages to their practitioners and/or care team? In addition, what is the average response time to patient messages?
- How frequently are patients accessing their patient portal?

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

Provide timely appointments for your patients by offering same-day or next-day access. Your practice should aim to provide timely access to the patient's own practitioner and/or care team for urgent care and transition management. Providing ample same-day and next-day appointments will better equip your practice to meet patient demand for access. A commonly used measure of the availability of timely appointments is the "third next available appointment." It is defined as the "average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment

Learn more about the IHI third next available appointment.

for a new patient physical, routine exam, or return visit exam." Long patient waits for the third next available of any appointment type indicate that demand for appointments surpasses your practice's supply, and means patients do not have suitable access.

Expand your office hours. By offering visits to patients outside of traditional office hours (e.g., in the early morning or evenings), your practice will allow patients to access the right care at the right time. Appropriately investing in expanded office hours balances supply and demand, and reduces the delay between when the demand is initiated and when the service is delivered.

In this context, you can match the "supply" or the availability of clinical resources (i.e., the practitioner and/or care team) to the "demand" (i.e., the requests for appointments on any given day). Comparing supply and demand will help your practice determine how many and what types of appointments to make available. Think about engaging your PFAC for input on how and when to schedule those appointments to reduce access concerns, as well as how to optimally meet the needs of your patient population.

Offer alternatives for care outside of traditional office visits. While all CPC+ practices are encouraged to provide care outside of traditional office visits to their patients, Track 2 practices are expected to build this capability. As you continue to increase your percentage of CPCP, consider expanding your successful alternative care strategies to other populations of patients, as appropriate, and/or explore other opportunities to provide care in new and innovative ways to address the needs of other patient populations.

You should start by identifying which type of patient you want to target for alternative care. You can assess your patient population to determine which patients would benefit the most from alternative care.

You might start by asking yourselves the following questions:

- Which of our patients are at higher risk for adverse outcomes? Out of those patients, who needs more time during a visit or has difficulty getting to our office?
- Do we have high-risk patients with common chronic conditions who need additional self-management support (SMS) and who could benefit from education on lifestyle changes and peer support provided through group visits?
- Do we have the capacity to deliver home visits to patients recently discharged from the hospital or frail, elderly patients, where we can more adequately assess needs for caregiver support, medication management, and community-based services?

You can also use data from your EHR or health IT software to assess patients who are at higher risk for poor outcomes and who many benefit from alternative care.

Key Insights

Examples of alternative care may include, but are not limited to:

- E-visits (e.g., planned visit via secure email and secure messaging)
- Telehealth (e.g., planned visit provided via secure, live-streaming video)
- Telephone visit
- Home visits
- Group visits

There are many different strategies you can use to increase patients' access to care teams and to sustain continuity of care for your patients, but you should start with the one or two alternative care modalities that best meet the needs of your patient population. As part of the planning process, you should also consider implications for clinical workflow and documentation:

- How will we schedule patients for alternative care?
- Who on the care team will be involved in implementing alternative care approaches?
- How will we document the care delivered through alternative care provided to patients?
- How will we develop new practice policies and workflows for alternative care?
- How will we track the effectiveness of alternative care on patient outcomes?

Learn how a CPC Classic practice, St. Elizabeth Physicians, decided to offer patients the option of virtual treatment for non-urgent medical issues. Read this spotlight to learn how this practice's early adopters, Karl Schmitt, MD, and Bradley Gray, DO, embraced the innovation and led efforts to convince their colleagues to do so too.

Because the CPCP is calculated from your historical Medicare FFS revenue, it can be used to pay for activities that are billable under the Medicare Physician Fee Schedule for Medicare beneficiaries. For Track 2 practices, your CPCP is designed to give you more flexibility in how you provide care beyond traditional office visits. When you use your CPCP, you are not required to submit a bill for the services and your documentation should be what is needed for the clinical care you provide. You may also use your CPCP for office visits that are more extensive or time-consuming than the billable code(s) cover.

As you make progress implementing alternative care, consider how you will measure the impact of your alternative care on quality, cost, and/or patient experience of care. Depending on the type of alternative care your practice provides, you might consider measures that can help you assess improvements in access to care, utilization of specialty services, hospital admissions/readmissions, and care continuity. As with any new practice improvement, start with a small number of patients, evaluate what worked well and what you can improve, and then slowly expand your strategy to more patients and additional care teams as appropriate.

Optimize continuity with the practitioner and/or care team

Defining the change

Care continuity is at the heart of comprehensive primary care. At its core, it represents the ability of your practice to know and care for its patients over time. Continuity is best described through three dimensions: informational, longitudinal, and interpersonal continuity.[10]

Change Tactics	
1.	Document all care provided in the practice in the same electronic health record.
2.	Measure care continuity between patient and practitioner and/or care team.

- *Informational continuity* means that practitioners have access to information on patients' past events and personal circumstances to inform current care decisions (e.g., via the EHR).
- *Longitudinal continuity* refers to ongoing patterns of health care visits that occur with the same practice over time.
- *Relational continuity*, a specific type of longitudinal continuity, refers to the therapeutic relationship between a patient and a practitioner and/or care team that is characterized by personal trust and accountability.

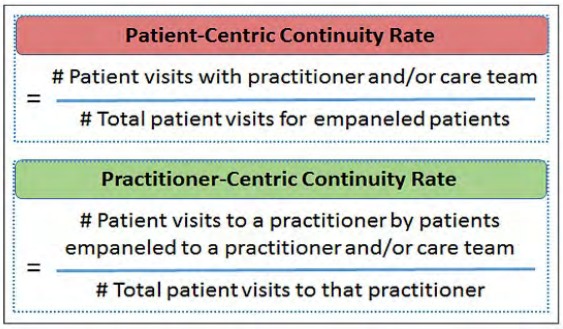
All three components of continuity improve patient outcomes and experiences of care. Key tactics related to optimizing continuity are summarized in the Change Tactics table above.

Document all care provided in the practice in the same electronic health record. To provide continuity efficiently and effectively, you will want to ensure the practitioner and/or care team document all care provided in the practice in the EHR. The EHR is an essential platform for your care teams to address patient care needs during and outside of your office hours. It serves as a hub for patients' medical records and care history. The EHR should be an accessible, centralized tool that can, in real time, receive and record updates from the care team and any practitioner who contributes to your patients' care. By providing practitioners and care team members access to the EHR, you can ensure that the care provided to patients is accurate and continuous.

Measure and analyze continuity of care. Your practice should develop the capability to measure relationship continuity for empaneled patients using your EHR, practice management software, or other tracking mechanisms. Measuring continuity of care between patient and practitioner and/or care team allows you to track improvements over time.

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

Practices vary in how they measure continuity. Some practices measure continuity with a practitioner (i.e., MD/DO, NP, or PA), while others choose to measure it in reference to the care team responsible for the panel of patients. Some practices measure continuity only in terms of visits, while others capture non-visit-based care in the measurement.



To measure continuity, first, you should ensure your entire patient population is empaneled to a practitioner or care team. Second, choose a consistent way to measure continuity of care.

Two common methods practices can use to measure continuity are patient-centric and practitioner-centric measures. Either approach supports the goal of ensuring patients are able to see their practitioner consistently.

- *Patient-centric continuity* is the total number of visits (including alternative care) to a practitioner by all patients empaneled to that practitioner divided by the total number of visits by that patient panel to any practitioner or care team at your practice. For example, if a practitioner's panel of patients makes 4,000 primary care visits in a year, with 3,000 of those visits to the patients' own practitioner and 1,000 to other primary care practitioner, the patient-centric continuity rate is 75 percent.
- *Practitioner-centric continuity* is the total number of visits to a practitioner (including alternative care) by patients empaneled to that practitioner divided by the total number of visits conducted by that practitioner. If a practitioner provides 3,000 visits in a year and 2,000 are visits by patients in his or her panel, the practitioner-centric continuity rate is 66.6 percent.

Function 2: Care Management

Care management is working with and for patients, generally occurring outside of traditional medical care (e.g., face-to-face office visits), to support optimal management of complex care. Care management is a resource-intensive intervention and will have its greatest impact when it is targeted to those most likely to benefit. A typical primary care practice serving a diverse patient population will target relationship-based, proactive care management to less than 10% of its patient population.

Identifying the patients likely to benefit from care management necessitates a view of the whole population served by your practice, those who seek care only in crisis as well as those who are seen more regularly. Selecting patients for care management requires risk stratifying your entire population served.

Primary care has historically used care management in an ad hoc way for patients who present with clear and immediate needs. In the delivery of comprehensive primary care in CPC+, your practice will use processes and systems to identify patients most likely to benefit from care management and will reliably provide care management services aimed at reducing hospitalizations and crisis-driven care while improving quality of life and health outcomes.

CPC Classic practices taught us that there are two cohorts of patients likely to benefit from different approaches to care management:

1. **Patients with some combination of multiple comorbidities, complex treatment regimens, frailty and functional impairment, behavioral and social risks, and serious mental illness benefit from long-term, relationship-based (longitudinal) care management. This is patient-centered care at its best, with care management supported by protocols tailored to the specific needs, circumstances, and conditions of the patient.** Routine and acute visits are augmented by intentional, proactive outreach at regular intervals by a care manager who can then intensify touches during exacerbations and transitions. These patients are identified through the two-step risk stratification process that uses an algorithm to roughly stratify the practice into risk cohorts, followed by clinical judgment and intuition to adjust and refine the risk status of individual patients.
2. **Otherwise stable patients undergoing transitions in care, those with new serious illness or injury involving complex treatment regimens, newly unstable chronic illness, or undergoing transition in the setting of care from hospital or nursing home benefit from short-term, goal-oriented (episodic) care management.** Practices use the “triggering event” to identify those patients most likely to benefit from episodic care management.

Function 2 Requirements

Program Year 1 (2018 Starters)

a. **Track 1:** Risk stratify all empaneled patients.
b. **Track 2:** Use a two-step risk stratification process for all empaneled patients:
   - Step 1. Based on defined diagnoses, claims, or another algorithm (i.e., not care team intuition); and
   - Step 2. Add the care team's perception of risk to adjust the risk stratification of patients, as needed.
c. Provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, based on a defined risk stratification process and who are likely to benefit from intensive care management.
d. **Track 2:** Use a plan of care centered on patients' actions and support needs in management of chronic conditions for patients receiving longitudinal care management.
e. Provide short-term (episodic) care management along with medication reconciliation to a high and increasing percentage of empaneled patients who have an emergency department (ED) visit or hospital admission/discharge/transfer and who are likely to benefit from care management.
f. Ensure patients with ED visits receive a follow-up interaction within one week of discharge.
g. Contact at least 75% of patients who are hospitalized in target hospital(s), within two business days.

Program Year 2 (2017 Starters)

a. Use a two-step risk stratification process for all empaneled patients, addressing medical need, behavioral diagnoses, and health-related social needs:
   - Step 1. Use an algorithm based on defined diagnoses, claims, or other electronic data allowing population-level stratification; and
   - Step 2. Add the care team's perception of risk to adjust the risk stratification of patients, as needed.
b. **Track 2:** Maintain and review a two-step risk stratification process for all empaneled patients, addressing medical needs, behavioral diagnoses, and health-related social needs:
   - Step 1. Use an algorithm based on defined diagnoses, claims, or other electronic data allowing population-level stratification; and
   - Step 2. Add the care team's perception of risk to adjust the risk stratification of patients, as needed.
c. Based on your risk stratification process, provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, and likely to benefit from intensive care management.
d. **Track 2:** For patients receiving longitudinal care management, use a plan of care containing at least patients' goals, needs, and self-management.
e. Provide short-term (episodic) care management, including medication reconciliation, to patients following hospital admission/discharge/transfer* and, as appropriate, following an ED discharge.
f. Ensure patients with ED visits receive a follow-up interaction within one week of discharge.
g. Contact at least 75% of patients who were hospitalized in target hospital(s)* within two business days.

**including observation stays*

Assign and adjust risk status for each patient

Defining the change

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

Risk stratification is a dynamic process that includes your entire population of patients (regardless of payer or insurance status), and moves beyond solely identifying your high-risk patients. This process allows your practice to have a population perspective and develop strategies to address patients at high and/or rising risk (e.g., uncontrolled chronic conditions, high utilization of hospital and/or ED, social needs), while also meeting the preventive care needs of low-risk patients. Assigning a risk status or score to each empaneled patient gives you a more actionable view into the needs of your patient population, and offers you the ability to target care management resources more effectively. Key tactics related to assigning and adjusting risk status are summarized in the Change Tactics table.

FAQ: Can we use the CPC+ attribution report and hierarchical condition category (HCC) scores to generate our risk scores for risk stratification?

Answer: No, the CMS-HCC risk score included in your attribution report and the process of risk stratification are different.

- *Risk stratification assigns a risk status to each patient, which gives you a more actionable view into the needs of your patient population.*
- *Medicare's CMS-HCC risk scores included in your attribution report only apply to your attributed Medicare patients and are used for purposes of payment.*

Unlike CMS-HCC risk scores, risk stratification should be applied across all of your patients, regardless of insurer or attribution status. It is critical that you use a consistent method to assign and adjust risk to all your patients. There are a variety of algorithm-based methods available, using utilization, co-morbid conditions, EHR, and claims data. Note that the assigned risk status your practices assigns may differ from the CMS-HCC risk score CMS assigned for purposes of payment.

Use a consistent method to assign and adjust risk. Risk stratification is optimally a sequential two-step process: (1) An algorithm that uses some combination of clinical and historical data (e.g., from the EHR, utilization data, and/or claims) to provide a rough segmentation of the entire patient population, and (2) Apply information the practitioner/care team has about the patient (clinical intuition and judgment) to segment the population by risk.

Algorithm-based risk stratification alone often misses patients (up to 20 percent) who might benefit from care management services.[11] The addition of clinical intuition (practitioner and/or care team judgment) adds sensitivity and specificity to the identification of these patients by incorporating the care team's knowledge of patients and their context. A blended approach using both an algorithm-based method and clinical intuition is the best method to ensure the high-risk and high-need patients are appropriately targeted for care management.[12]

- **Step 1: Algorithm-based method. Choose a risk stratification algorithm or process for your practice.** All members of your care team should understand the risk stratification methodology you select, and it should align with your care management strategy. The various risk stratification methodologies categorize patients into as few as three levels (low, medium, and high risk) and as many as seven levels. There is no clearly proven optimal algorithmic approach. Practices have effectively used claims data, diagnoses and diagnoses clusters, clinical data in structured fields within the EHR, and combinations of the above. Practice have used vendor-provided analytic software and customized algorithms in their EHR. It is important that this first step be automated, that it use the power of analytics to roughly segment the entire practice population as a starting place for the second step.

  Using Risk Stratification to Target Care Management Resources
  This spotlight explores how Mercy Family Medicine incorporates its own two-step risk stratification to identify patients for longitudinal care management.

- **Step 2: Add clinical intuition/care team perception to refine the algorithm's risk identification process.** Clinical intuition is simply adjusting the risk score based on information not available through the structured fields and data sources the algorithm uses. This might include patients' social needs, health literacy, activation, family or caregiver support, or a behavioral or medical need not accounted for in Step 1. This process can be more or less structured; some practices use standardized tools (e.g., the Patient Activation Measure, functional assessment, and cognitive testing) to assist in this step, others rely solely on the accumulated knowledge of the practitioner and care team. This step should be familiar to most; it is a part of daily clinical practice in primary care. What is different in CPC+ is the inclusion of this step in a standard and consistent way to identify patients likely to benefit from care management, enhanced by skills, tools, and judgments traditional to primary care.

Health IT workflow and functionality clearly is a critical component to the development of your risk stratification methodology. Explore the risk stratification functionalities of your EHR or other

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

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

add-on software. Some vendors provide guides and tutorials on the workflow and functionality for capturing and reporting patient risk levels. Some questions you may want to ask your vendor include:

- Can we automate the risk assessment/scoring?
- How will we clearly identify risk level in the patient record so it is easily seen by all users?
- How do we change the risk score on an ad hoc basis?
- How do we flag high-risk patients?
- How do we generate reports of patients in each risk tier (both the number and list of patients)?

This is not a one-time process. It's important to recognize that a patient's level of risk is not static. Patients move in and out of risk levels regularly. Therefore, you'll want to reassess individual patient's level of risk on a regular basis throughout the year, as well as the distribution of risk across your population and how that changes over time. Formal risk stratification for the entire panel of patients should occur at least once per year.

Monitor the risk stratification method. You will want to review and refine your methodology over time, learning from your experience and the experience of other CPC+ practices on what is working to identify patients who benefit from care management with reduction in utilization, improved health outcomes, and improved quality of life. Periodically reassessing the effectiveness of the risk stratification process to identify high-risk patients should become a routine task for your practice.

One strategy to reassess effectiveness of the process is to evaluate results to determine distribution of patients across risk levels, especially the highest and next highest risk levels. While your particular population may vary, a typical population distribution has about 3-5% of the patient population at high risk, with no more than 10% of the population receiving care management services. You can capture this information in graph form to illustrate the distribution of patients across risk levels.

Displaying the data using a graph or a similar visual can help you to assign and adjust resources as necessary, while tracking your results over time. We can monitor how patients are moving between levels by running the data on a monthly or quarterly basis.

Practice Spotlight: Heeding the Signs: Know When It's Time to Modify Your Risk Stratification Methodology

This spotlight features Freeman Family Medicine and its strategy for identifying solutions to adjust its risk stratification methodology to accommodate its patient population.

When assessing the risk stratification methodology, consider the following:

- Are there patients who would benefit from care management, but are not being identified by the algorithm? Are there criteria that need to be added to the algorithm to better capture these patients in risk identification?

- Does our practice have patients who have been identified as “high risk,” but who should have been scored as “lower risk?”
- Are our clinicians reviewing their list of high-risk patients and providing feedback on accuracy?

When assessing the risk stratification workflow, consider the following:

- Who in our practice is involved in assessing and assigning risk scores?
- How and when do we reassess and adjust risk scores?
- How do we flag high-risk patients and who is responsible for doing this?
- How are high-risk patients referred to care management?

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

Defining the change

The goal of **longitudinal care management** is to improve health outcomes and quality of life and reduce hospitalization and crisis-driven utilization of health care for patients with complex care needs. Five percent of patients incur nearly fifty percent of health care costs, and there is growing evidence that investing resources in these individuals can improve care while decreasing costs.[13]

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

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

Use the risk stratification process to identify and target care management services to patients whom the care team believes to be at high risk and amenable to outreach. We have discussed how a formal two-step risk stratification process is used to identify patients most likely to benefit from the relatively scarce resource of care management. However, not all patients identified through the risk stratification process will be amenable to team-based, care management.

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

- Some patients don't feel connected enough to the practice to accept the more intensive relationship involved in care management.
- Some patients have effectively organized family and friends to help them with their care, essentially creating their own care management team.
- Some patients refuse services.
- Some patients have strong existing relationships with other providers, including specialists (e.g., nephrologists, oncologists), private care managers, and institutional care providers, who meet their needs. In fact, increasingly, CPC+ care managers are finding that patients are engaged with other care management resources, such as hospital-based care transition teams and specialist care navigators (e.g., in cancer care), or Accountable Care Organization (ACO)-based care management resources. How to coordinate and avoid duplication with these other resources is an area of active learning for CPC+.

Key Insights

Essential Components of the Care Manager's Roles and Responsibilities for Patients in Longitudinal Care Management

- Support patient self-management support and activation.
- Oversee linkages to community resources and social support.
- Oversee coordination of care transitions and closely follow up.
- Coordinate closely with those involved in the patient's care, including primary care practitioner, behavioral health care manager/primary care behaviorist, comprehensive medication management specialist, and consulting providers.
- Receive and review timely information on hospital and emergency department admissions.
- Document activities in the medical record.

Finally, it is important to recognize the dynamic nature of this work. You will want to be sure you have a process to graduate patients who no longer require this intensive and expensive resource so that you accept new patients and still maintain a panel size appropriate for your care manager(s).

Use on-site, non-physician, practice-based, or integrated shared care managers to proactively monitor and coordinate care for the highest risk cohort of patients, with assistance from other practice staff, as needed. A critical step toward integrating longitudinal care management into your practice is to determine care management job responsibilities within the care team. Many practices hire a dedicated staff member for care management functions (e.g., care manager, care coordinator, patient navigator). Care management staff members are typically in the nursing or social work disciplines and are trained to manage patients with complex health needs. Multiple team members, including physicians, non-physician practitioners, and other disciplines, may engage in care management,

CPC Practice Spotlight: Social Worker Contributes to Collaborative, Team-based Care Management

An Oklahoma practice added a part-time social worker to expand its care management expertise. Learn how this practice identified the need, created the position, and recruited a person with the right skillset for the team.

but each patient at high risk should have a clinically trained individual in the practice who is accountable for these high-risk patients' active, ongoing care management that goes beyond office-based clinical diagnosis and treatment.[14]

Key Insights

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

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

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

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

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

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

In CPC+, care management is a critical function of primary care and care managers are fully integrated members of the care team. This integration promotes close coordination and communication within the team and provides capacity to respond rapidly to patient needs.

Care management activities should be a structured part of the medical record, and capture critical information. Your practice's EHR should clearly define and track patients in care management with the aid of the EHR registry functionality or through a stand-alone registry. Care management of these patients includes monitoring of clinical data used to manage chronic conditions, as well as interventions triggered by regularly scheduled and ad hoc reviews. Documentation of care management activities in the EHR should include: the nature and

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

substance of contacts, data that review assessment of status, changes to care pathways or the overall care plan, unresolved questions, and next scheduled follow-up contact or review.

Care management activities should include providing proactive care that moves beyond traditional office visits or crises (e.g., ED care or hospitalization) and is not primarily visit-based**.** While office visits are opportunities to define goals, plan patient care, engage in shared decision making, and build a trusting relationship, most care management activities take place by phone, patient portal, e-mail, mail, or home visits (as well as visits to skilled nursing facilities or hospitals to support transitional care). Your practice should appropriately target these activities based on patient needs.

CPC+ practices have varied approaches for care management, including the following:

- Care managers belonging to the practice work as part of one or more care teams.
- Care managers are organized centrally within a health care organization/system, but are fully embedded in a practice and care team(s).
- Care managers may be shared across smaller practices or practice sites, and embedded in these practices and care team(s).

FAQ: Can I use a care manager based at the health plan to provide care management services for the health plan's beneficiaries?

Answer: No. Care management is most effective when the care manager is fully integrated and embedded into the care team. Individuals providing care management services should be able to build trust with patients and all members of the care team. Care management should be targeted based on patient need, not the patient's payer. In addition, practitioners at your practice should have open communication and oversight of the care managers serving your patients.

Develop a personalized and documented care plan. A care plan is a mutually agreed upon and documented plan of care based on the patient's goals, needs, and self-management activities, and is accessible to all team members providing care for the patient. All high-risk patients receiving longitudinal care management should have a personalized care plan developed in a joint conversation between the patient and care team.

The care plan should be structured and standardized. Critical elements for a care plan may include, but are not limited to: treatment goals and intervention as identified by the care team, the patient's overall health goals; advance directives and the patient's preferences of care, key contact information for the practice, actions that the patient and his or her care team will be taking, and the most important contingencies (e.g., "if/then" for the specific patient and his or her conditions).

The care plan implemented in your practice does not need to follow any specific template, but should be patient friendly and limit use of unfamiliar medical jargon and acronyms. It should be a tool that limits duplicative documentation within your EHR, fits within your existing workflow, and is accessible and valuable to patients and caregivers. The care team should have real-time/point of care access to a patient's care plan in the patient's medical record. It is important to maintain current and up-to-date medical records in the EHR.

When developing the care plan template and clinical workflow, consider the following:

- What elements will we include in the care plan?
- How many patients will we target for care planning, with a focus on high-risk patients?
- Who in our practice is responsible for updating the care plan? When will we update the care plan?
- Once implemented, how can we improve the care plan? How will we solicit patient and staff feedback on successes and identify areas for improvement?

Health IT Enhancements for Care Plans (Track 2 Only)

(To be available in your clinical workflows no later than January 1 Program Year 3)

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

a. This tool should enable the care team to electronically capture the following care plan elements:
   - Advance directives and preferences for care
   - Patient health concerns, goals, and self-management plans
   - Action plans for specific conditions
   - Interventions and health status evaluations and outcomes
   - Identified care gaps

b. The practice should have the ability to customize which of these elements are included within the care plan and how these elements are displayed.

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

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

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

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

g. To support this objective, practices must adopt certified health IT that meets the 2015 Edition "Care Plan" criterion found at 45 CFR 170.315(b)(9),

Provide episodic care management, including management across transitions and acute care needs

Defining the change

Those patients whom practices do not otherwise target for longitudinal care management may receive short-term (episodic) care management services. Episodic care management supports patients with various needs, such as those transitioning care to home or another setting, a new diagnosis or injury, exacerbation of a chronic condition, or clinical instability. Patients in episodic care management will require coordination of services and medication reconciliation.[15]

Change Tactics	
1.	Provide short-term (episodic) care management services to patients identified with acute or urgent needs (e.g., new diagnoses, medical crisis, decompensation in otherwise controlled chronic condition).
2.	Provide care transition planning and follow-up, including medication reconciliation, for patients with recent hospitalization.
3.	Provide necessary follow-up and medication reconciliation following emergency department (ED) discharge.

There are a variety of successful transitional care models for episodic care management that you could adapt for the primary care setting. Examples include C-TraC, which is a telephone-based, protocol-driven transitional care program by a nurse care manager;[16] Care Transitions Intervention; the Transitional Care Model; and Project RED.

Regardless of the model you choose, timely follow-up is key to avoiding adverse outcomes for patients transitioning care to home or another care setting.[17] In addition, focusing care management activities around communication between practitioners across settings, access to services, and adequate patient and caregiver support can help reduce costs and improve patient safety.[18] Key tactics related to episodic care management are summarized in the Change Tactics table. As described below, several guiding principles exist for event-triggered, episodic care management.

Provide short-term (episodic) care management services to patients identified with acute or urgent needs (e.g., new diagnoses, medical crisis, decompensation in otherwise controlled chronic condition). Episodic care management includes coordination and transitions of care, support to manage symptoms, and reconciliation of patients' medications. Below are examples of the several ways to identify patients for episodic care management:

[15] Gilmore-Bykovskyi, A. (2014, Feb. 1). Development and Implementation of the Coordinated-Transitional Care (C-TraC) Program. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3954808/

[16] Gilmore-Bykovskyi, A. (2014, Feb. 1). Development and Implementation of the Coordinated-Transitional Care (C-TraC) Program. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3954808/

[17] Dreyer, T., (2014, Feb. 15). Care Transitions: Best Practices and Evidence-based Programs. Retrieved from http://www.chrt.org/publication/care-transitions-best-practices-evidence-based-programs/

[18] Gilmore-Bykovskyi, A. (2014, Feb. 1). Development and Implementation of the Coordinated-Transitional Care (C-TraC) Program. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3954808/

- Recent or frequent hospital admissions or ED visits
- Patients with a new major illness or exacerbation of a chronic condition
- Initiation or stabilization on a high-risk medication (e.g., warfarin)
- Individuals experiencing a transition in their care setting (e.g., between hospital, skilled nursing facility [SNF], home care, and/or assisted living)
- Life events, like the death of a spouse or financial issues, or psychosocial concerns, as addressing these matters via episodic care management may prevent future health-related issues

Episodic Care Management Focused on High-Risk Patients

This spotlight highlights Foresight Family Physicians' implementation of an episodic care management program focused on high-risk patients employing data, coordination, and collaboration.

Your contact may be frequent initially, but will be short-term in nature with resolution once your practice addresses the triggering event. The care team should work with patients engaged in episodic care management to determine the timing and setting for regular follow-up, either by phone, e-mail, or in-person. Some practices have initiated home visits to support patients during an episode of risk and/or transition of care. Some patients will only need care management services for several weeks or months, while other patients may need to transition into longitudinal care management services.

Key Insights

Essential Components of Episodic Care Management:

- Follow up with patients who have visited the ED within one week of discharge.
- Contact at least 75% of patients who are hospitalized in target hospital(s) within two business days.
- Identify patients with new diagnosis, injuries, and exacerbations of illness.
- Ensure clinical monitoring and interventions by team members.
- Create an accurate list of medications through medication reconciliation.

Over time, your practice may want to assess panel size and workflow for episodic care management and adjust these processes, matching resources to need. You'll also want to assess the impact of episodic care management on care, utilization, cost, and patient experience. Your practice can assess this impact by evaluating CMS and other payer data, as well as practice-generated data. These data will also assist you in refining the process of patient selection for episodic care management.

Provide patients with care transition planning support and follow-up. Episodic care management includes supporting patient transitions following an ED visit or hospitalization. Set a goal and ensure that the majority (e.g., 75%) of patients receive post-discharge episodic care management through their transition to home or other care setting. Your practice should obtain complete and timely communication of information from the discharging facility**.** Also, discuss the transition of care at discharge with your patients and their caregivers. Ideally, this discussion will occur at the time of discharge, but no later than within two days of discharge from hospital admission or observation stay (and within one week of discharge from the ED).

You can decide on the appropriate form of contact on a case-by-case basis. Some patients may require outreach by phone, while other patients should be seen in person. Essential information to review during follow-up includes reason for admission, test and procedure results, discharge instructions, medication reconciliation, follow-up appointments, caregiver status, and need for other home-based or community services and support.

Conduct medication reconciliation. Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking (including drug name, dosage, frequency, and route) and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications to the patient at all transition points. Medication reconciliation may reduce the number of incorrectly prescribed or adjusted medications, and may also catch potentially damaging discrepancies in dosage or duplicate therapies.

FAQ: What is the difference between episodic care management and care coordination?

Answer: Episodic care management is "person-focused," in that it supports individuals in the management of their own care through a period of risk. Examples can include working with patients in between visits through coaching and other strategies in partnership with their primary care practitioner to achieve their health goals, such as improving diet/exercise, checking on daily weights for heart failure patients, or reviewing the action plan for asthma patients. Care management includes calls to follow up with patients after a transition of care to review medication lists, check on status, and evaluate patient concerns/answer questions/triage for primary care follow-up.

On the other hand, care coordination is "system-focused." Care coordination ensures adequate flow of information and resources between systems, including the necessary infrastructure to do referral tracking and follow up with patients after an ED visit. For example, care coordination can include establishing collaborative care agreements with specialists, working with facilities (SNFs, hospitals, EDs) to obtain a flow of information (via HIE, other health IT, phone, fax, etc.) about patients admitted, with a change in status, or discharged. Care coordination is "system-focused."

Function 3: Comprehensiveness and Coordination

Comprehensiveness in the primary care setting refers to your ability to address your patient population's medical, behavioral, and health-related social needs. You can address these needs by adding services and capabilities to your practice, as well as through closely coordinating care that can be better provided outside of the practice. Comprehensiveness adds both breadth and depth to the delivery of primary care services, and builds on the element of the relationship that is at the heart of effective primary care. It is associated with lower overall utilization and costs, less fragmented care, and better health outcomes.[19]

Coordination refers to the work of bridging the gaps between systems of care. Primary care practices have traditionally played this critical role for their patients. As a CPC+ practice, you will build processes that reliably coordinate care, focusing on timely hospital and ED discharge follow-up, as well as coordinating between primary care and specialty care, and between primary care and community-based services. This coordination involves understanding the network of services available to your patients, both within the medical neighborhood and within the community.

To build your practice's comprehensiveness and create stronger linkages with clinical and community-based services, you'll want to begin by assessing the needs of your patient population and services provided by asking the following questions:

- What is the prevalence of health conditions and concerns within our practice? What data are available to us to determine prevalence of conditions within our practice?
- What is the scope of services provided to our patients? Is there a need for services that we don't currently offer?
- Where are we commonly referring our patients, and is there an opportunity to bring some of those services into our practice?
- How can we develop more collaborative relationships with the health care professionals caring for our patients outside of our primary care practice? How do we share the care of our patients and create better feedback loops?
- Is there an opportunity to play a more meaningful role in other settings of care (e.g., hospitals, skilled nursing facilities)?

As you enhance your comprehensiveness and coordination, you will use answers to these questions to develop strategies to improve care, including: seeking training to add or deepen clinical skills, developing new or modifying current workflows to address needs commonly seen in your patient population, establishing formalized relationships with specialists regarding shared responsibilities for patient care, and building relationships with community services to meet health-related social needs.

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

These change concepts are ways in which CPC+ practices use comprehensiveness and coordination to achieve better health outcomes, improved patient experience, and reduced utilization and cost of care:

- Integrate behavioral health clinicians into the primary care setting and workflow.
- Implement behavioral health care management for patients with mental health conditions.
- Use evidence-based screening and case-finding strategies to identify individuals at risk and in need of behavioral health services.
- Manage medications to maximize efficiency, effectiveness, and safety.
- Provide effective care coordination, navigation, and active referral management in the medical neighborhood.
- Establish effective linkages with neighborhood/community-based resources to support patient health goals and health-related social needs
- Increase capability to manage medical conditions in the primary care setting that meet the needs of the practice population.

Function 3 Requirements

Program Year 1 (2018 Starters)

a. Systematically identify high-volume and/or high-cost specialists serving the patient population using CMS'/other payers' data.
b. Identify hospitals and EDs responsible for the majority of your patients' hospitalizations and ED visits, and assess and improve timeliness of notification and information transfer using CMS'/other payers' data.
c. **Track 2:** Enact collaborative care agreements with at least two groups of specialists, identified based on analysis of CMS/other payer reports.
d. **Track 2:** Choose and implement at least one option from a menu of options for integrating behavioral health into care.
e. **Track 2:** Systematically assess patients' psychosocial needs using evidence-based tools.
f. **Track 2:** Conduct an inventory of resources and supports to meet patients' psychosocial needs.
g. **Track 2:** Characterize important needs of subpopulations of high-risk patients and identify a practice capability to develop that will meet those needs, and can be tracked over time.

Program Year 2 (2017 Starters)

a. Enact collaborative care agreements with at least two groups of specialists identified based on analysis of CMS/other payer reports.
b. Using CMS/other payers' data, track timeliness of notification and information transfer from hospitals and EDs responsible for the majority of your patients' hospitalizations and ED visits.
c. Develop a plan for implementation of at least one option from a menu of options for integrating behavioral health into care, based on an assessment of practice capability and population need.
d. **Track 2:** Develop a plan to provide comprehensive medication management to patients discharged from the hospital and those receiving longitudinal care management.
e. **Track 2:** Advance implementation of at least one option from a menu of options for integrating behavioral health into care.
f. **Track 2:** Address common psychosocial needs for at least your high-risk patients:
    - Routinely assess patients' psychosocial needs.
    - Prioritize common needs in your practice population, and maintain an inventory of resources and supports available to address those needs.
    - Establish relationships with at least two resources and supports that meet patients' most significant psychosocial needs.
g. **Track 2:** Define at least one subpopulation of patients with specific complex needs, develop capabilities necessary to better address those needs, and measure and improve the quality of care and utilization of this subpopulation.

Integrate behavioral health clinicians into the primary care setting and workflow

Defining the change

Behavioral health care is an umbrella term for care that addresses mental health and substance use conditions, health behavior change, life stresses and crises, and stress-related physical symptoms.[20] Behavioral health conditions frequently co-exist with chronic medical conditions. Compared to patients with only one health condition, health care for patients with co-existing conditions costs as much as seven times more.[21]

Key Insights

Behavioral health processes for your practice to consider:

- Establish a process to identify patients with behavioral health needs and at high risk for poor outcomes.
- Assess workflows to:
  - Ensure systematic measurement of symptom severity (e.g., PHQ9) at baseline for patients with mental health conditions.
  - Ensure systematic and ongoing measurement of symptom severity after treatment initiated.

Integrating behavioral health in primary care can address many of these problems. By effectively integrating behavioral health into primary care, $26 billion to $48 billion could be saved, which could decrease overall U.S. health care spending by 5-10%.[22] Moreover, improving behavioral health treatments has the potential to improve mental health and general medical outcomes, and lower costs. Integrating behavioral health also improves physician self-efficacy and decreases the risk of burnout.

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

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

- Primary Care Behaviorist model
- Care Management for Patients with Mental Health Conditions

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

[21] Thorpe, K., Jain, S., & Joski, P. (2017). Prevalence and spending associated with patients who have A behavioral health disorder and other conditions. *Health Affairs*. Retrieved from https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.0875?journalCode=hlthaff

[22] Floyd, P. (2016). Integrating physical and behavioral health: a major step toward population health management. Retrieved from http://www.bdcadvisors.com/integrating-physical-and-behavioral-health/

CPC+ strategies have a whole person orientation; improve access to services; enhance communication; and support patient-engaged, planned health care. Over the course of CPC+, your practice may progress along a continuum from simple coordinated care with behavioral health practitioners to fully integrated care that meets patients' behavioral health needs.

Read more about the characteristics of the two CPC+ Behavioral Health Integration Options.

When choosing a behavioral health integration strategy from the two menu options (please see Figure 2 below), your practice may want to consider:

- Developing a clear rationale, vision statement, and leadership buy-in to support behavioral health integration implementation
- Developing a behavioral health integration team to spend focused time on this work (e.g., quality improvement team, primary care champion, behavioral health champion, management, EHR champion, clinical staff)
- Prevalence, severity, and range of mental health/substance use conditions in the population served by the practice
- The anticipated scope of your integrated behavioral health program (e.g., which conditions and patients you will target)
- Current or planned practice-based screening for mental health and substance use conditions and psychosocial stressors

Use this worksheet to help plan your implementation of the CPC+ Primary Care Behaviorist model.

- Existing resources, including care manager background/interest/training in behavioral health, physical space, teleconferencing equipment, and community resources, including behavioral health specialists
- New resources needed to achieve the integrated care goals, including capital investments, personnel, team building and diversity training activities, and technology costs
- The most financially viable strategy
- The challenges you anticipate in implementing behavioral health services

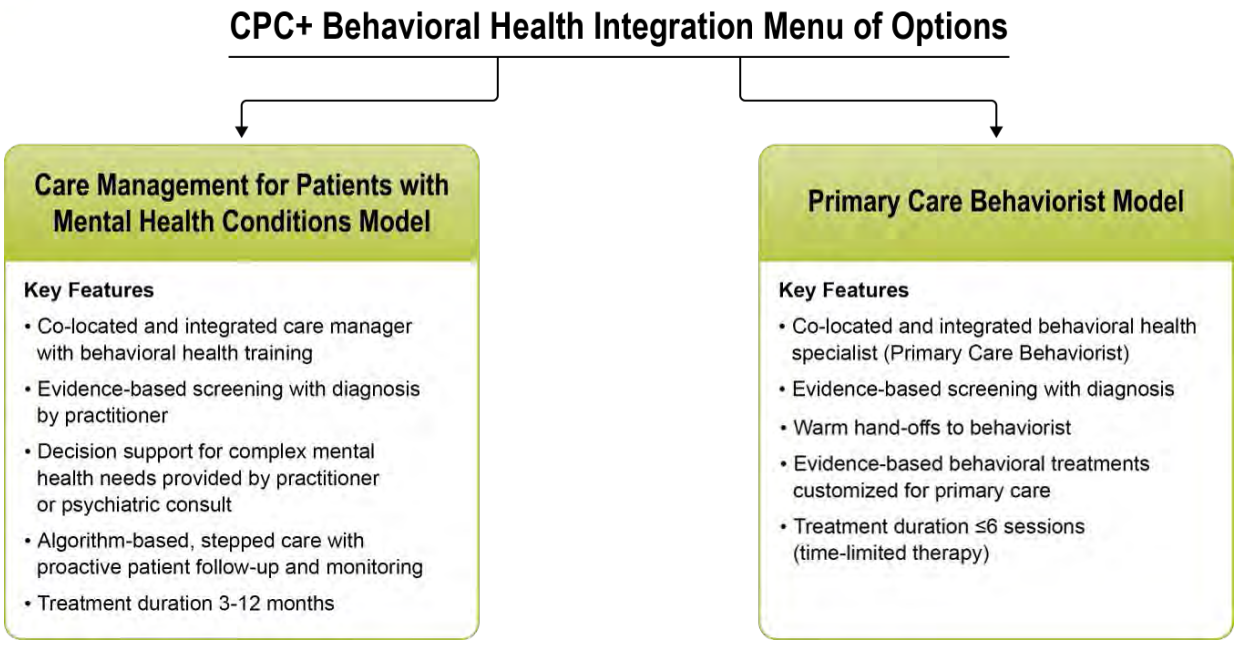


Figure 2: Overview: CPC+ Care Delivery Behavioral Health Integration Menu of Options

Primary Care Behaviorist Model. The Primary Care Behaviorist model integrates behavioral health into the primary care workflow through warm handoffs to a co-located behavioral health professional who can diagnose and address mental health conditions in the primary care setting, implement behavioral strategies for management of chronic general medical conditions, and facilitate engagement of specialty care (i.e., triage) for serious mental health conditions and substance use conditions. This model is population-based, provides same-day access (e.g., appointment or a brief, initial, introductory contact), is time-limited (e.g., usually six sessions or fewer), and can address a range of mental health conditions and behavioral health needs.

Team building and training to work effectively are critical, regardless of the option your practice chooses to implement. Key tactics related to implementing the Primary Care Behaviorist model of integration are summarized in the Change Tactics table.

Incorporate appropriately trained and licensed staff into the primary care team to provide evidence-based behavioral health treatments and time-limited therapy. Having your appropriately trained and licensed behaviorist (e.g., co-located Licensed Clinical Social Worker, Psychiatric Nurse Practitioner, Psychologist) located at your practice is a key feature of the Primary Care Behaviorist model.

Change Tactics	
1.	Incorporate appropriately trained and licensed staff into the primary care team to provide evidence-based behavioral health treatments and time-limited therapy
2.	Use evidence-based, stepped care treatment algorithms that match treatment to patient preferences and consider response to prior treatments
3.	Conduct regular case reviews with care team members, for at-risk or unstable patients and those who are not responding to treatment

Primary care remains the way most patients access care for behavioral and mental health

conditions. By making the behaviorist more accessible through co-location and full integration into the care team, your practice can provide care in a more timely and effective manner. The behaviorist should be an integrated team member who has knowledge and understanding of the patient's medical needs. Integrated behavioral health and primary care team members get to know each other's style of care and begin to blend styles and delivery of services.[23] Warm handoffs from the practitioner (or other care team member) can increase successful contact between the behaviorist and patient, and help patients feel more comfortable in starting the relationship.

FAQ: Do patients need to see the behaviorist in our office?

Answer: If your practice chooses to implement the Primary Care Behaviorist model, you will co-locate behavioral health specialists at your practice. There is no co-location time requirement, but these specialists should be able to address a variety of mental illness and behavioral health needs, and should be available to provide same-day access with warm handoffs.

Provide evidence-based behavioral health treatments by your primary care behaviorist through time-limited therapy (usually six sessions or fewer). Behaviorists will use evidence-based behavioral treatments customized for primary care.

Treatment decisions should be made with the patient, based on the most current evidence with consideration of patient preferences. Updates to care should consider patient response to prior treatments, and include clinical care team members as appropriate.

Integrating Behavioral Health Through Partnerships

This spotlight highlights Grants Pass Clinic's successful implementation of the Primary Care Behaviorist Model through integrated and co-located behavioral health services, including mental health and substance use disorder counselors, into its practice.

Conduct regular case reviews with the practitioner, behaviorist, and other care team members for at-risk or unstable patients and those who are not responding to treatment. The care team regularly reviews the patient's treatment plan and status and maintains or adjusts treatment, including a referral to a behavioral health specialty care as needed. An essential element of the integrated Primary Care Behaviorist model is effective communication among practitioners. Integrated care teams describe using three types of communication to be an effectively integrated team: clinical case review, day-to-day operational communication, and process communication.

[23] CIHS. (2014, March). Essential Elements of Effective Integrated Primary Care and Behavioral Health Teams. Retrieved from https://www.integration.samhsa.gov/workforce/team-members/Essential_Elements_of_an_Integrated_Team.pdf

Implement behavioral health care management for patients with mental health conditions

Defining the change

Use care managers with behavioral health training to support management of patients receiving behavioral health treatment. Individuals with identified mental health conditions should be offered proactive, relationship-based care management, specific to the mental health condition. Care management for patients with mental health conditions differs from disease management for chronic medical conditions in the following respects:

- The care manager has specific training in mental health, and may have training in behaviorally based brief therapy (e.g., problem-solving therapy [PST], behavioral activation).
- Systematic screening is more critical to identifying patients.
- The care manager has a role in confirming diagnosis and screening for alternative or comorbid psychiatric diagnosis.
- Severity monitoring (e.g., PHQ9 scores) is more important.
- Stepped care algorithms are often applied more formally.
- Decision support is received from the care team and psychiatric consultant.

Change Tactics	
1.	Use care managers with behavioral health training to support management of patients receiving behavioral health treatment
2.	Provide self-management support and treatment monitoring for patients with mental health conditions.
3.	Use a registry or health IT registry functionality to support active care management and outreach to patients in treatment.
4.	Use professional decision support, such as a psychiatric consult for patients with complex mental health needs.
5.	Ensure regular communication and coordinated workflows between primary care, behavioral health practitioners, and community services.

Your practice can deliver care by a team that involves a primary care practitioner as the treating practitioner, a care manager (often, a behaviorally trained nurse) who provides self-management support (SMS) and additional follow-up contacts, and a consulting psychiatric professional or primary care practitioner with special interest and training in behavioral health who supports the care manager and provides decision support. Key tactics related to implementing care management for patients with mental health conditions are summarized in the Change Tactics table.

FAQ: Where might we find behavioral health (BH) trainings for care managers?

Answer: Practices may find BH training for care managers at local universities and behavioral health/mental health specialty programs. Some training can be completed as self-study (e.g., learning to administer and interpret standardized instruments) or through internet-based training (e.g., University of Washington Advancing Integrated Mental Health Solutions Center).

Use care managers with behavioral health training. Care managers who have the role of providing care management for patients with mental health conditions should have specific training and skill sets related to managing behavioral health conditions. Typical skills and training include: ability to confirm diagnoses and screen for alternative or comorbid psychiatric diagnosis (using structured approaches and/or standardized instruments), skill in severity monitoring (using standardized instruments, such as PHQ9), psycho-education about behavioral health conditions, and skills to assess and promote adherence to the treatment plan, Your behavioral health care manager can operate using a stepped-care approach with guidance from well-defined algorithms and protocols under clinical guidance of the primary care physician and/or consulting Psychiatrist or Psychiatric Nurse Practitioner. In some instances, care managers may have training in brief therapies, such as PST or behavioral activation.

Provide self-management support and treatment monitoring. Self-management support activities and strategies should be used with patients with mental health conditions to optimize their ability to manage their condition. Your behavioral health care manager should conduct frequent planned follow-up (often, by telephone) to assess treatment response and reinforce treatment adherence, which facilitates ongoing monitoring and bringing patients back in for care prospectively. You may **use a registry or health IT registry functionality to support active care management and outreach to patients** during their treatment and throughout the behavioral health care management engagement.

Incorporate professional decision support, such as psychiatric consultation, to guide care of patients with complex mental health conditions. Primary care providers, behavioral health care managers, and psychiatric consultants can work together to care for complex patient and monitor progress. Programs that use this model have improved clinical outcomes and reduced costs.[24] The psychiatric consultant (e.g., preferably a Psychiatrist or Psychiatric Nurse Practitioner, but this role could also be filled by a primary care practitioner with special interest/training in behavioral health) can work closely with the behavioral health care manager to provide decision support. The consultant should be accessible telephonically with access to clinically relevant patient information. In addition, the psychiatric consultant, along with the primary care provider, may help guide patients in pharmacological treatments and care plans.

[24] CIHS. (n.d.) SBIRT: Brief Interventions. Retrieved from https://www.integration.samhsa.gov/clinical-practice/sbirt/brief-interventions

Develop workflows that support regular communication and coordination. The psychiatric consultant provides support by regularly reviewing the clinical status of patients receiving behavioral health services and assisting the primary care practitioner and behavioral health care manager with care coordination. Consider the following in developing roles and communication with the psychiatric consultant, who may:

- Advise the primary care team regarding patient diagnosis
- Provide options for resolving issues with patient response to behavioral health treatment
- Make adjustments to behavioral health treatment for patients who are not progressing
- Manage any adverse interactions between the patient's behavioral health and medical treatments
- Facilitate referral for behavioral health specialty care when clinically indicated[25]

The primary care team should regularly review the patient's treatment plan and status with the psychiatric consultant. Your practice may utilize health IT or other secure technology to enhance communication between the primary care practitioner, behavioral health care manager, psychiatric consultant, and community services. The behavioral health care manager can serve as a central hub of communication, working with the patient to navigate and understand information and resources.

[25] CMS. (2017, May). Medicare Learning Network (MLN) Fact Sheet: Behavioral Health Integration Services. Retrieved from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

Use evidence-based screening and case-finding strategies to identify individuals at risk and in need of behavioral health services.

Defining the change

Change Tactics	
1.	Routinely screen patients for depression, anxiety, dementia, and other mental health conditions.
2.	Integrate Screening, Brief Intervention, and Referral to Treatment (SBIRT), an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs into the practice setting.

Routinely screen for depression, anxiety, dementia, and other mental health conditions. Regular screenings in primary care enables earlier identification of mental health and substance use disorders, which translates into earlier care.[26] You can incorporate evidence-based screenings as a diagnostic tool used by the patient's practitioner for select behavioral and mental health conditions, and use these screening to monitor patient needs over time. Evidence-based screening can also help your practice identify when there may be a need for brief interventions, and can motivate individuals to change their behavior by helping them understand how their substance use puts them at risk and to reduce or give up their substance use.[27]

Evidence-based screening tools your practice may use include the following:

- PHQ-2 or PHQ-9 (depression)
- GAD-7 (anxiety disorder)
- Mini Mental Status Examination or the Mini Cog (dementia)
- AUDIT-C and DAST (substance abuse)
- Adult attention-deficit/hyperactivity disorder (ADHD) self-report tool

Key Insights

Behavioral Health Training and Protocols for your Practice:

- Train the entire care team on the purpose and utility of identification and screening.
- Train clinical personnel on the role of the behavioral health specialist and when and how to access services.
- Consider having staff complete initial screening as part of check-in.
- Develop a handoff protocol when a patient needs behavioral health and social services.
- Determine how screener results will be documented and tracked.

Integrate Screening, Brief Intervention, and Referral to Treatment (SBIRT). SBIRT is an evidence-based practice used to identify, reduce, and prevent problematic substance use. SBIRT is an early intervention approach for individuals with nondependent substance use to effectively help them before they need more extensive or specialized treatment. This approach differs from the primary focus of specialized treatment of individuals

[26] Substance Abuse and Mental Health Services Administration/Health Resources and Services (SAMHSA-HRSA) Center for Integrated Health Solutions (CIHS). (n.d.) Screening Tools. Retrieved from https://www.integration.samhsa.gov/clinical-practice/screening-tools

[27] SAMSHA/HRSA CIHS. (n.d.) SBIRT: Brief Interventions. Retrieved from https://www.integration.samhsa.gov/clinical-practice/sbirt/brief-interventions

with more severe substance use or those who meet the criteria for diagnosis of a substance use disorder. SBIRT consists of three major components:

Implementing Behavioral Health Screening Protocols: A Practice Example

In this video, Family Care Southwest discusses the types of behavioral health screening protocols used in the practice and how often those protocols are applied.

- **Screening.** Screening/Assessing a patient for risky substance use behaviors using standardized assessment tools
- **Brief Intervention.** Engaging a patient showing risky substance use behaviors in a short conversation, and providing feedback, motivation, and advice (e.g., motivational interviewing, problem-solving therapy, cognitive behavioral therapy)
- **Referral to Treatment**. Providing a referral to brief therapy or additional treatment to patients whose assessment or screening shows a need for additional services[28]

Brief interventions typically last from 5 minutes of brief advice to 15 to 30 minutes of brief counseling, depending on patient need. Interventions are meant to support behavior change for patients with substance use conditions. Behavioral health specialists are trained in behavioral therapies and collaborative communication to work effectively with patients with substance use conditions. They can provide health coaching to patients who are committed to changing unhealthy behaviors, improve patients' understanding of and adherence to agreed-upon care plans, and support patients' self-management goals. Integrate behavioral health specialists within your care teams to coordinate care and use self-management care plans to support communication of patient's goals and preferences across the care team.

Manage medications to maximize efficiency, effectiveness, and safety

Defining the change

Medication management is an evidence-based approach to improving patient outcomes. Comprehensive medication management (CMM) ensures practices individually assess patient medications to determine that each medication is appropriate for the patient, effective for the medical condition, safe (given comorbidities and other medications taken), and able to be taken by the patient as intended.

CMM supports the CPC+ aims to improve the quality and experience of patient care and decrease beneficiaries' total cost of care. Specifically, evidence suggests that CMM is associated with improved medication-related therapy outcomes, decreased utilization of health care services, increased patient satisfaction, and lower health care costs.[29]

[28] CMS. (2017, March.) MLS Booklet: Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services. Retrieved from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SBIRT_Factsheet_ICN904084.pdf

[29] American College of Clinical Pharmacy. (2016). Comprehensive medication management in team-based care. Retrieved from https://www.accp.com/docs/positions/misc/CMM%20Brief.pdf

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

Change Tactics	
1.	Conduct comprehensive medication reviews with patients that include action plans, individualized therapy goals, and planned follow-up, particularly for high-risk patients.
2.	Provide medication self-management support to improve adherence to prescribed medication.
3.	Work together with pharmacists and other health care professionals to promote clinically sound, cost-effective medication therapy and therapeutic outcomes (i.e., provide formulary management).
4.	Integrate a pharmacist into the care team to provide medication management services.

Conduct comprehensive medication reviews with patients that include action plans, individualized therapy goals, and planned follow-up, particularly for high-risk patients who:

- Experience a transition of care
- Receive longitudinal care management
- Take high-risk medication

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

As part of your care management strategy, your practice should develop a process to identify individuals at risk of medication therapy problems. Your practice can target patients recently discharged from the hospital and those receiving longitudinal care management, as these patients—particularly those with multiple chronic conditions—are often on several medications and may benefit from CMM support.

CMM is of the greatest benefit to:

- Patients who have not reached or are not maintaining the intended therapy goal
- Patients who are experiencing adverse effects from their medications
- Patients who have difficulty understanding and following their medication regimen
- Patients in need of preventive therapy
- Patients who are often readmitted to the hospital[30]

Work together with pharmacists and other health care professionals (i.e., a CMM specialist) to promote clinically sound, cost-effective medication therapy and therapeutic outcomes (e.g., provide formulary management). For patients at high risk of experiencing medication therapy problems who are referred to the CMM specialist (staffing described below), important elements include:

- Initial patient assessment, including a review of medical records and medication history

[30] American College of Clinical Pharmacy (ACCP). (n.d.) Comprehensive Medication Management in Team-Based Care. Retrieved from https://www.accp.com/docs/positions/misc/CMM%20Brief.pdf

- A conversation between the patient and caregiver with the CMM specialist to determine appropriateness of current medications (i.e., effectiveness, safety, affordability, therapy adherence);
- Identify medication-related problems
- If necessary, evaluate the need for therapy interventions

When selecting a CMM specialist, your practice should first consider pharmacists who have extensive experience with medications, medication therapy, and drug-related adverse effects, and who have practiced in a team-based setting. When such pharmacists are unavailable, CMM services can also be accomplished by providers with prescriptive authority, such as a Physician, Nurse Practitioner, or Physician Assistant. CMM specialists should have specific training in medication management or have an interest in receiving training/certification in CMM services. Your team could also consider partnering with local resources and professionals when building capabilities in comprehensive medication management at your practice.

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

Defining the change

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

Change Tactics	
1.	Ensure routine and timely follow-up to ED visits and hospitalizations.
2.	Work with targeted hospitals where the majority of your patients receive services to achieve timely notification and transfer of information following hospital discharge and ED visit.
3.	Establish collaborative care agreements with frequently used or high-cost specialists and/or care agencies (e.g., home health agencies, skilled nursing facilities) that set expectations for documented flow of information and practitioner expectations between settings.

Patients and both primary and specialty care practitioners report substantial frustration with poor outcomes from fragmented care across the medical neighborhood. Research clearly identifies communication gaps from primary care when initiating referrals and from specialty care in the referral response.[31] Patients are often unclear of their role in the referral, adding to the risk during these transitions.

Tracking referrals and developing collaborative care agreements with specialty care practices your patients use frequently and determining which are high-cost practices can improve both your practice's satisfaction with the referral process and your patients' outcomes. Key tactics

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

related to care coordination in the medical neighborhood are summarized in the Change Tactics table.

The flow of patient information between institutional and ambulatory settings is often limited, at best.[32] Primary care physicians are often uninvolved in inpatient care and unaware when patients are discharged. Without appropriate post-discharge follow-up, patients are at risk for post-discharge complications and worsening of their condition.[33] Improving your practice's communication with institutional settings, as well as your practice's involvement in the care of patients in these settings, may help avoid unnecessary hospitalization, readmission, and care in other institutional settings. You should leverage available health IT systems to efficiently facilitate communication across the medical neighborhood and reduce unnecessary services.[34]

Timely follow-up after ED or hospitalizations can improve patient outcomes and decrease readmissions. Your practice can identify and **work with target hospitals and EDs where the majority of your patients receive these services to achieve timely notification and transfer of information following hospital discharge and ED visits.** To ensure safe and effective transitions of care through episodic care management (see above), your practice should consider the following questions:

- How do we know if our patients are seen in an ED or admitted to/discharged from a hospital?
- How will information about the ED visit or hospitalization come to our practice (e.g., HIE, hospital portal, hospital generated report, EHR or other health IT software)?
- How will that information be incorporated into the patient's medical record so that the information is available at the time of the follow-up visit or other patient contact?
- How will the patient be contacted following the ED visit or hospitalization?
- Who will need in-person follow-up and what timeframes will be feasible and effective?
- What will happen in the follow-up visit to ensure seamless care?

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

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

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

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

Key Insights

A Stepped Approach to Developing Relationships with Facilities Serving Your Patient Population

- Identify target community facilities used by the majority of your patient population. Include hospitals, urgent care centers, skilled nursing and extended care facilities, behavioral health (BH) organizations, and rehabilitation facilities
  - Work with other CPC+ practices in your area to develop expectations collaboratively when working with target facilities.
- Meet with key staff from each facility's leadership, admissions, and hospital ED. Include a member of these facilities' IT department if possible. These individuals will be instrumental in formatting the flow of communication between your practice and the facility.
- Develop a clear workstream with designated points of contact for the patient, caregivers, and facility.
- Consider developing a formal or informal agreement that identifies the roles of each facility and a communication plan with established timeframes for sending information.

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

A collaborative care agreement lays out expectations between a primary care practice and another health care practitioner. Some core elements of a collaborative care agreement[35] include:

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

Practices should establish collaborative care agreements with at least two specialists whom your patients frequently see and/or who are high-cost. Your practice should identify and test process and outcome metrics that will allow you to assess the impact of collaborative care agreements with specialists.

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

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

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

Timely Communication to Improve Readmission Rates

This spotlight explores the steps CPC+ practice Maron and Rodrigues Medical Group took to foster timely communication and home visits after hospitalizations to improve readmission rates.

- Develop the collaborative care agreement with the specialists chosen, outlining the responsibilities of both parties, including information you can give to educate your referred patients. Once you develop and refine your initial collaborative care agreements, you can broaden your use to include other specialists.
- Ensure the timely exchange of necessary information**,** ideally electronically, between your practice, specialists, and patients.

FAQ: What elements should I include in a collaborative care agreement between my practice and a specialist?

Answer: A collaborative care agreement aims to improve the patient experience; reduce delays, miscommunications, and gaps in care; lower costs by eliminating unnecessary services; and improve quality and patient safety. The agreement should:

- *Outline responsibilities of both parties*
- *Ensure timely exchange of necessary information (electronically)*
- *Ensure provision of up-to-date clinical records*
- *Include co-management arrangements with specialists*
- *Define responsibilities for patient care and communication throughout the referral process*

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

Defining the change

Extensive research has demonstrated the impact of social factors (e.g., income, education, access to food and housing, employment status) on the patient's ability to reach his or her health goals. Research attributes most health outcomes to social, environmental, and economic factors.[36] Interdisciplinary care teams and community linkages are key to addressing health concerns and social needs. Rather than having an exhaustive list of resources, your practice will want to identify a few resources within the community that are the most meaningful and meet the majority of your patients' needs.

Change Tactics
1. Use and integrate a health-related social need screening tool/question(s) that will identify community and social service needs among the patient population, including a universal screening for all patients and a targeted screening for patients with complex needs.
2. Develop and use a database of community and social services that is updated regularly.
3. Establish relationships with community resources that support your patients' most significant social needs.
4. Formalize coordination agreements to facilitate information sharing and linkages with community-based agencies and services.
5. Track and measure success rates of linkages to community resources.

Addressing common psychosocial needs for at least your high-risk patients requires you to:

- Routinely assess patients' psychosocial needs
- Prioritize common needs in your practice population and maintain an inventory of resources and supports available to address those needs
- Establish relationships with at least two resources and supports that meet patients' most significant psychosocial needs

Your practice can develop a process to periodically assess data on the common needs of your patient population and prioritize strategies to help patients meet those needs. Communicate the common social needs and inventory of resources to your entire care team. As you progress, develop a process to track outcomes of resource connections made for patients. Key tactics related to establishing effective linkages to support patient goals and social needs are summarized in the Change Tactics table.

The HealthLeads screening toolkit provides your practice with a template to screen your patient population for social needs.

Use and integrate a health-related social need screening tool/question(s) that will identify community and social serivce needs among the patient population, including a universal screening for all patients and a targeted

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

screening for patients with complex needs. Screening your patient population for those with significant unmet social needs is a vital first step to understanding many of the key factors that undermine patients' health and ability to execute their practitioners' recommendations. Your practice can identify and adapt a tool to use for standardized assessment of patients' psychosocial needs (e.g., food, housing, social isolation, insurance, interpersonal violence, emotional well-being, transportation), beginning with your high-risk patients.

Many patients may not volunteer that they are experiencing these challenges during a brief interaction with a practitioner. Ensuring your practice is asking the right questions, in a way that elicits candid responses, will allow you to learn the prevalence and impact of unmet social needs on your unique population. Consider using a screening tool to allow for systematic assessment and determine, based on practice and community resources, the potential needs you will assess (e.g., housing, food, transportation, exposure to violence, job insecurity). Your practice may want to identify where in a patients' record you will document the assessment and, as a team, act or refer for urgent and high value needs that emerge from routine assessment.

Develop and use a database of community and social services that is updated regularly. Your practice should develop a process to ensure reliable resource connections for patients with common social needs in your patient population. You can take advantage of local or state organizations that maintain and regularly update databases of community-based resources and support, such as "211," a free and confidential service that helps people find local resources. Your practice staff can identify community resources through previous experience, and by staying apprised of new resources that become available. Patients, caregivers, and colleagues are also valuable sources of information on how responsive and effective they find local services.

Establish relationships with community resources that support your patients' most significant social needs. After identifying available community resources, you should effectively coordinate community and social services for your patients as needed, and follow up with patients at regular intervals. Your practice may want to build close relationships with community-based organizations to streamline resource connections. It may take time and several conversations to build relationships, so consider focusing on developing relationships with only one or two community-based organizations at a time. The goal is to find common ground and focus on the structure and process of referrals, and bi-directional flow of information. Like with specialist referrals, it is important to **coordinate referrals to community and social services and follow up with patients referred for services.** Work with patients to ensure there is a shared understanding of the purpose of the referral.

Tracking the success of linkages of patients to community resources can also be valuable. It will inform individual patient care, and help inform your practice on the utility and/or accessibility of community resources. Successful referrals can help you determine the most useful and available resources in your community. The key is to have a few quality and accessible resources for your patients, as opposed to extensive lists of unused and unverified resources.

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

Defining the change

Change Tactics	
1.	Use payer data to identify common and complex health conditions seen in the population and develop strategies to address these needs in the practice.
2.	Expand collaboration with specialists to include strategies like co-location and co-management for common conditions.

Comprehensiveness in the primary care setting refers to the availability of a wide range of services in primary care, as well as care for the depth and breadth of the health needs in the population of a primary care practice (e.g., treating chronic kidney disease beyond stage 2, or treating a variety of rheumatological or orthopedic problems, if these issues are common in your practice). Higher levels of comprehensive care are associated with lower overall utilization and costs, as well as better health outcomes.

The payment structure in Track 2 of CPC+ is designed to provide practices with time and resources to provide the more resource-intensive care required by patients with complex needs. For many practices, the ability to provide more comprehensive care within your practice will require acquisition of new knowledge, skills, and/or additional staff. Your practice may need to adjust its scheduling protocols.

CPC+ offers your practice resources to improve and increase the amount of time spent with patients, and to reduce unnecessary referrals for care that could potentially be addressed in primary care. You will build capacities to treat “the whole person” and manage a wider array of conditions appropriate for primary care. Practices and their owners likely need to review their approach to measuring practitioner and care team productivity to ensure they account for and reward the time required to provide more comprehensive care.

This process starts with understanding the needs of your specific patient population, facilitated through the review of available data, practitioners’ and care teams’ experience, and your patients’ experience at your practice (e.g., through conversations with your PFAC). By better understanding your patient population’s needs, you can define conditions or subpopulations within your practice to increase comprehensiveness. To inform decisions about where to concentrate your efforts, it is also important your practice understands current practice resources and interests, as well as the availability of specialty resources in the community. Finally, your attention to important outcome measures for the subpopulation(s) being addressed will ensure that changes in your practice are resulting in improved care at lower cost.

Use payer data to identify common and complex health conditions seen in the population and develop strategies to address these needs in the practice. Your practice can use both qualitative and quantitative data to identify potential subpopulations with needs that can be met by your practice, improve the quality of care, and decrease costs. You may prioritize subpopulations and

health needs to address, based on impact and feasibility. Your practice can use data from the CPC+ Practice Feedback Report, data provided by other payers, and those derived from your practice's EHR or other health IT software to consider questions like the following:

- What are common diagnoses prompting referrals that might be managed in our practice if we had different capabilities? Why do we currently refer these patients out, instead of managing them in our own practice?
- Which specialty referrals result in higher costs and offer opportunities to provide expanded services within our practice, if we had different capabilities?
- Which referrals could be managed through consultation with the specialist, resulting in better, more cost-effective care through co-management, rather than specialty management?
- When are we referring patients for services (e.g., diabetes education) that could be provided in our practice?

Clinical and support staff can provide insight into questions like the following:

- Which specialty services are inconvenient for our patients, either because of long wait times for appointments or travel distance?
- Which specialists have less effective processes for communicating patient information (e.g., care plans) and closing referral loops, making care coordination more challenging?
- Which specialists are especially good at communicating patient information (e.g., care plans) and closing referral loops, and would be amenable to a co-management model?
- What are common problems or diagnoses that lack adequate support within our community, and could we provide that support within our practice (e.g., dementia, frailty, palliative care)?

Expand collaboration with specialists to include strategies like co-location and co-management for common conditions. This assessment of patient and population needs should generate a list of opportunities to increase comprehensiveness, either through development of a new practice capability or by expanding collaboration with specialists to include strategies like co-location and co-management for common conditions. CPC+ is designed to give your practice flexibility to pursue opportunities to improve care that would not be feasible in a solely fee-for-service (FFS) environment. Most often, these services will include components of care that are directly reimbursable and some that are not.

Function 4: Patient and Caregiver Engagement

Patient and caregiver engagement means putting patients and families at the center of care. Your care team will build collaborative relationships with patients in support of their health goals and utilize your patients' critical input to improve processes and accelerate practice change.

As your practice works towards improving care so it is patient-centered, high-quality, and cost-effective for patients and families, you will focus on these four change concepts:

- Engage patients and caregivers to guide improvement in the system of care.
- Integrate self-management support into usual care across conditions.
- Engage patients in shared decision making.
- Partner with patients and caregivers in advance care planning.

Function 4 Requirements

Program Year 1 (2018 Starters)

a. Convene a PFAC at least once in PY 2018, and integrate recommendations into care, as appropriate.
b. **Track 2:** Convene a PFAC in at least two quarters in PY 2018 and integrate recommendations into care, as appropriate.
c. Assess practice capability and plan for support of patients' self-management.
d. **Track 2:** Implement self-management support for at least three high-risk conditions.

Program Year 2 (2017 Starters)

a. Convene a PFAC at least three times in PY 2018 and integrate recommendations into care and quality improvement activities, as appropriate.
b. **Track 2:** Convene a PFAC at least quarterly in PY 2018 and integrate recommendations into care and quality improvement activities, as appropriate.
c. Implement self-management support for at least three high-risk conditions.
d. **Track 2:** Identify and engage a subpopulation of patients and caregivers in advance care planning.

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

Defining the change

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

Change Tactics
1. Establish a PFAC to work on procedures, processes, and quality improvement strategies to achieve high-quality, coordinated, and patient- and family-centered care in the practice.
2. Ensure patients are directly involved in the practice's transformation team.
3. Communicate to patients, families, and caregivers about the changes being implemented by the practice.
4. Regularly assess the patient care experience and engage patients as partners through surveys and/or other mechanisms.

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

Establish a Patient and Family Advisory Council (PFAC) to work on procedures, processes, and quality improvement strategies. A PFAC is an established council within a practice that meets regularly and consists of patients who receive care at the practice and their caregivers. Patients can contribute to making improvements to the practice in a variety of ways (e.g., surveys, suggestion boxes, focus groups, interviewing potential hires). CPC+ practices have found PFACs to be an extremely efficient and effective strategy to understand and motivate changes to better meet patients' needs.

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

Your practice will recruit and then periodically assess your PFAC membership. Your PFAC should consist of patients and/or their caregivers who are representative of your patient demographic (e.g., ethnicity, race, cultural groups, socioeconomic status, gender identities, sexual preferences, age). Patients and their caregivers do not need special qualifications or expertise. An individual's experience as a patient or caregiver in your practice is most critical. Ask your care team for suggestions of patients whom they think would be interested in participating and who could be effective in working with the practice on improvements. Outline expectations of participation, including responsibilities of the patient advisor role, term limits, frequency and location of meetings, and anticipated time commitment outside of in-person meetings.

Learn how CPC+ practices Batesville Family Practice Clinic, Capital Care Medical Group, and Family Medical Group developed their PFACs.

Identify discrete tasks that the PFAC can undertake, such as providing advice on patient orientation tools or assessments. Examples of PFAC recommendations from CPC+ practices include: requiring all staff to wear nametags; implementing user-friendly changes to the phone system, such as not signing out to answering services at lunchtime; developing patient communications to promote preventive screenings; helping develop new visit types; and providing input into treatment options and care quality.

Ensure patients are directly involved in the practice's transformation team. Inform the PFAC of your participation in CPC+, and your current and upcoming focus of practice transformation activities. Solicit ideas directly from these patient advisors about how to improve practice functions; as your main customers, they will have many useful ideas for you to hear. Consider inviting two to three of your PFAC patient advisors to participate in improvement activities. Some patient advisors might be willing to increase their involvement in practice improvement efforts. For example, you could invite patient advisors to attend standing meetings (e.g., weekly, bimonthly) with your practice's quality improvement team, take a turn at leading the meetings, or provide feedback on improvement activities in real time. Collaborate with your quality improvement team to determine what improvements to prioritize.

FAQ: We are a system-owned practice. Should every practice in our system establish a PFAC?

Answer: Yes, if your practice is affiliated with other CPC+ practices, it is still critical to convene a PFAC for each practice location. When you engage patients and families, you gain an understanding of how the practice works from a patient's perspective, and how you can enhance your system of care. Much of this feedback will be practice location-specific, and your PFAC will be most valuable if it addresses the specific experience of care for patients and your staff at each of your practice locations. Your patients will also be more likely to share their ideas for improvement with staff they already are familiar with and know from the practice.

Communicate to patients and their caregivers about the changes being implemented by the practice. Inform patients and their caregivers on how input from patient advisors has spurred specific efforts for improvement in your practice. You can use multiple methods to effectively convey this information, such as a practice newsletter, website, patient portal, posters in the waiting room, social media, or updated hold messages on phone lines. You may want to ask your PFAC for recommendations on which method is best to convey information to your patients.

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

Communication is important in building confidence that patient and caregiver input is valued and incorporated into practice improvement efforts. Provide feedback on progress and outcomes of

past agenda items. Acknowledge the advice of patient advisors and report back what ideas, changes, and any other results have come from the PFAC and how many of the PFAC's suggestions have been implemented. Formalize a process for ensuring patient, caregiver, and community perspectives are incorporated.

As you advance the work of the PFAC, consider using the data you are collecting and evaluating to drive process improvement. Educating PFAC patient advisors in understanding how the practice uses data will assist in the decision-making process and provide direction on process improvement. You might also consider developing subgroups to work on and/or research projects based on the PFAC patient advisors' areas of interests.

Regularly assess the patient care experience and engage patients as partners through surveys and/or other mechanisms. Surveys are a common way to measure patient experience because you can use the resulting feedback to learn what your patients perceive as areas that need improvement and what works well for your patients. Different types of patient surveys can be inexpensive and efficient methods of gathering patient input. For example, your practice can do the following:

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

You can also use Consumer Assessment of Healthcare Providers and Systems (CAHPS) results and test use of patient focus groups, suggestion boxes, interviews, and other sources of feedback to better understand patients' experience of care at your practice. Other types of data your practice might use to gain insights into the patient experience include attendance rate at PFAC meetings, response rate and other analytics derived from patient experience surveys, and linking workflow and process changes to improved patient experience of care.

How to Hardwire Engagement into Care Delivery Processes is an external resource on the patient engagement survey from the New England Journal of Medicine (NEJM) Insights Council. This report compiles data from a survey of NEJM Catalyst Insights Council members (comprising health care executives, clinical leaders, and clinicians) about current trends in hardwiring patient engagement into care delivery processes.

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

FAQ: Can we provide an incentive of some type, such as food, for patients who attend our PFAC meetings, and can we use CPC+ resources to cover the expense?

Answer: Yes, CPC+ funds may be used to support your PFAC. Some practices recognize patient advisors' contributions by offering honoraria, such as gift cards or catering at meetings. Additionally, some patient and family advisors may not be able to participate in the PFAC without some form of reimbursement for their time or travel.

Integrate self-management support into usual care across conditions

Defining the change

Self-management support (SMS) gives your patients with chronic conditions tools to manage their health on a day-to-day basis and take an active role in their health care. SMS goes beyond supplying patients with information. It develops patient confidence by allowing patients to collaborate with the care team to set goals, regularly assess progress, provide problem-solving support, and make plans to live a healthier life. Patient follow-up is also a critical part of SMS to ensure patients are supported and accountable in achieving their goals.

Consider which patients will receive SMS, activities that will be performed with these patients, and which staff members will engage patients for SMS. Think about prioritizing the top two or three self-management tools and resources for priority conditions, and incorporating self-management interventions and outcomes into the patient's care plan. Use data from your EHR or other health IT software to identify prevalent conditions within your population (e.g., disease registries) and risk stratification tools to determine which patients will receive SMS. The California Healthcare Foundation cites seven essential activities in SMS:[37]

- Encouraging active participation in the management of the disease
- Collaboratively sharing information between the practice team and patient
- Teaching disease-specific skills
- Supporting healthy behavior change, including setting goals, making action plans, and linking patients with community resources
- Providing training in problem-solving skills
- Assisting with the emotional impact of having a chronic condition
- Ensuring regular and sustained follow-up

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

Conducting a practice needs assessment for SMS is a great way to understand current gaps in resources, services and supports, or staff training needs. By assessing your practices' current capabilities and opportunities for improvement, you can focus on actions the team can take to support self-management.

You can use the following process and outcome measures to track your practice's progress in implementing SMS strategies:

- 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
  - Percent 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.

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

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

Incorporate evidence-based approaches to promote collaborative self-management. Most primary care team members have limited or no training in patient activation, goal setting, or motivation techniques. By developing and providing formal, ongoing training for these skillsets, your practice can provide patients with greater support in self-management, which is believed to have a long-term impact on utilization patterns. There are two useful tools to help you assess and reinforce patient self-management skills:

- **Motivational interviewing.** A technique specifically designed to gain understanding from your patients' perspective, learn more about their underlying motivation, develop goals, create a plan, and determine the level of follow-up.
- **The Teach-back Method.** A communication confirmation method used by health care practitioners to confirm whether a patient (or caregiver) understands what practitioners are explaining to them. If patients understand, they are able to "teach back" the information accurately. This communication method is intended to improve health literacy.

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

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

There are a number of helpful tools you can use to assess the level of patients' receptivity to SMS, such as the Patient Activation Measure (PAM®) Survey and the How's Your Health assessment tools.[38]

Use group visits for common chronic conditions (e.g., diabetes). Group visits can be an effective way to have patients set goals and hold each other accountable to meeting those goals by reporting progress back to the group at each visit. Peer-to-peer sharing offers peer support and social interaction that increase a patient's comfort in discussing the topic. **Several options are available to provide such support, including providing condition-specific chronic disease self-management support programs or coaching, or link patients to those programs in the community.** In peer-led support groups or group educational classes, patients can hear and share real life examples that have been working—or not working—for others.

Provide self-management materials at an appropriate literacy level and in an appropriate language. Effective self-management hinges on patient engagement. A frequent barrier to patients' participation is not being able to understand the educational materials provided to them. Patients are often reluctant to admit they struggle with written documents. Accordingly, you will want to consider incorporating tools to assess patients' literacy levels, preferred language, and preferred teaching modality. You may want to use or create materials that are appropriate for

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

[38] Insignia Health. (2018). Patient Activation Measure® (PAM®). Retrieved from http://www.insigniahealth.com/products/pam-survey

lower literacy levels. You may find visual aids, photos, and illustrations helpful (e.g., recommended portion size for weight control programs).

Use a shared agenda for the visit and provide health coaching between visits. Asking patients about their priorities for the visit can help both practitioners and patients decide together what to cover during the visit. Setting the agenda together conveys to patients that they are active partners. Health coaching between visits allows practitioners opportunity to ask about any needs or barriers patients may have, provide education, link to additional resources, and help patients achieve their goals.

Learn how CPC Classic practices Corvallis Clinic and Warren Clinic implemented SMS and assessed their patients' health literacy.

Engage patients in shared decision making

Defining the change

Shared decision making is a process in which practitioners and patients work together to make decisions, and to select tests and treatment plans based on clinical evidence that balances risks and expected outcomes with patient preferences and values. When patients participate in shared decision making, they have the information needed to evaluate their options, understand what they need to do, and are more likely to follow through. Practitioners who use shared decision making say patients are more knowledgeable and better prepared for dialogue, are helped in their understanding of what practitioners are trying to do, and can more readily build a lasting and trusting relationship.

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

In many situations, there is no single "right" health care decision because choices about treatment, medical tests, and health issues come with pros and cons. Shared decision making is especially important in these types of situations. As a CPC+ practice, you will want to identify areas where your patients and the practice could benefit from more informed shared decision making, which could be specific to the complex, chronic conditions that are more prevalent in your patient population. While shared decision making is not a CPC+ care delivery requirement, it is a key strategy to engage patients. Key tactics related to shared decision making are summarized in the Change Tactics table above.

Engage patients in shared decision making about the risks and benefits of testing and treatments. Preference-sensitive care comprises treatments for conditions where the evidence does not support one, but rather several, options for treatment, which in turn involve significant

tradeoffs among the different possible outcomes of each treatment.[39] Decisions about whether and which of these interventions to use should reflect the patients' personal values and preferences, and should be made only after patients have enough information to make an informed choice, in partnerships with their practitioner.

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

Key Insights

List of Common Preference-Sensitive Conditions

- Management of chronic obstructive pulmonary disease (COPD)
- Management of asthma
- Management of coronary heart disease
- Management of congestive heart failure
- Management of peripheral artery disease (PAD)
- Management of hypertension
- Hyperlipidemia/high cholesterol
- Medications in diabetes
- Opioid misuse
- Tobacco cessation
- Management of anxiety or depression
- Chronic pain

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

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

[39] Center for Evaluative Clinical Sciences. (n.d.). Preference-Sensitive Care. Retrieved from http://www.dartmouthatlas.org/downloads/reports/preference_sensitive.pdf

evidence behind treatment options. In turn, this information as to treatment pros and cons helps make discussions easier for both the care team and the patient.

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

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

Once you have implemented shared decision making, you will want to gain feedback from staff and patients on successes and areas for improvement. Evaluate aspects of the workflow, such as who engages the patient in shared decision making, when is the patient engaged in shared decision making, and are the shared decision making tools successful in assisting the patient in making shared decisions. As the care team advances the use of shared decision making, you will want to consider ways your practice can measure the impact of shared decision making on patient outcomes.

Partner with patients and caregivers in advance care planning

Defining the change

Change Tactics	
1.	Identify the population(s) with whom the clinician engages in advance care planning conversations.
2.	Identify opportunities for visits with targeted patients, allowing adequate time for an advance care planning conversation.
3.	Document and communicate advance care discussions, including the patient's goals and preferences, in a manner accessible to the entire care team.

Advance care planning (ACP) allows patients to make plans about the care they would want to receive if they became unable to speak for themselves. Early conversations with patients about serious illnesses can improve the quality of care, leading to fewer non-beneficial medical interventions that conflict with patients' goals and less distress for families. [40] ACP is often initiated at an inappropriate time or too late in a disease course, such that the trajectory of care cannot be significantly altered.[41] Primary care teams build longitudinal, trusting relationships with patients and, thus, are the ideal personnel to address patient and caregivers' goals and

[40] Lakin, J.R., Koritsanszky, L.A., et al. (2014, September 17). Dying in America: improving quality and honoring individual preferences near the end of life. Available from http://www.nationalacademies.org/hmd/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx

[41] Mack, J.W., Cronin, A., Taback, N., Huskamp, H.A., Keating, N.L., Malin, J.L., et al. (2012, February 7). End-of-life care discussions among patients with advanced cancer: a cohort study. *New England Journal of Medicine.* Retrieved from https://www.jwatch.org/jw201202280000004/2012/02/28/end-life-care-discussions-among-patients-with

preferences at the end of life.[42] Key tactics exist related to ACP are summarized in the Change Tactics table.

Identify your high-risk subpopulation to target for advance care planning. Your practice should target your ACP efforts among a subpopulation of patients with serious illness, identified through your two-step risk stratification process. You can further limit your subpopulation to those who could benefit most from ACP (e.g., patients with a cancer diagnosis, end-stage kidney disease, heart failure, COPD, dementia, advanced age). By starting small, you can focus resources on improving this subpopulation of patients' care toward and at the end of life.

Identify opportunities for visits with targeted patients, allowing adequate time for an advance care planning conversation. The conversation is between a practitioner and patient about prognosis, values, goals, and care preferences in the context of advancing serious illness. Palliative care and family and caregiver support needs should also be addressed. These conversations typically begin with open-ended questions. Often, these conversations take place over time and should recur when there are significant changes in a patient's health. Clinicians and other practice staff may benefit from training and evidence-based conversation guides to facilitate this process.

The Serious Illness Conversation Guide provides instruction on how to initiate an effective and structured conversation with patients and caregivers about serious illness.

Document the advance care discussions. The care patients receive at the end of life is shared by several practitioners, is not site-specific, and includes outpatient and inpatient settings. The goal of documentation is to ensure that the patient's goals and preferences are reliably retrievable by all members of the care team. If the patient agrees, the discussion may lead to recording the key patient preferences in a legal document, such as an advance directive. You should strive for a systematic approach within your health IT to ensure consistent documentation.

These resources are written for patients and caregivers to help prepare them for advance care planning discussions and documenting treatment goals and preferences:

- Prepare for Your Care
- Five Wishes
- Physician Order of Life Sustaining Treatment (POLST)
- Respecting Choices (resources available for purchase)

Team members can help clinicians identify patients with serious illness, set up reminders to have the conversation with specific patients, and help coordinate care for patients after the conversations. This process of ACP implementation will evolve over time, requiring continuous quality improvement as you begin to include other subpopulations of patients.

[42] Lakin, J.R., Block, S.D., Billings, J.A., Koritsanszky, L.A., Cunningham, R., Wichmann, L., et al. (2016, September.) Improving communication about serious illness in primary care: a review. *JAMA Internal Medicine.* Retrieved from https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2532792?redirect=true

Once you know and have documented a patient's goals and prefences, it is important to ensure that your practice has processes in place to provide care consistent with the patient's goals and preferences through the end of that patient's life. This may include processes for patient and family/caregiver education on assessment and management of symptoms of deterioriating chronic conditions and the dying process, as well as assistance addressing social, spiritual, and cultural needs. You may also want to develop a multidisciplinary approach that includes outside practitioners who co-manage the patient's care (e.g., specialists, home health, hospice, community members) so that all of the patient's care remains consistent with his or her goals and preferences.

FAQ: What is the difference between "advance directives" and "advance care planning"?

Answer: Advance directives are legal documents that allow patients to specify what medical care they want when they cannot make medical decisions for themselves. Advance directives also enable patients to appoint someone to make medical decisions on their behalf.

Advance care planning (ACP) is a broader process of discussing and documenting a patient's goals and preferences for medical care at the end of life or other time when they cannot make the decision themselves. ACP may—and ideally, would—result in the creation of an advance directive; however, regardless of whether a patient signs an advance directive, ACP conversations documented in the medical record can provide valuable guidance for ongoing patient care. Ultimately, the goal of ACP is to ensure the patient's preferences and personal goals are considered during periods of serious illness and at the end of life.

Note: The definition of "advance care planning (ACP)" above is pertinent to CPC+, which is not to be confused with the Medicare billing definition of "advance care planning." CPC+ practices may or may not choose to bill the Medicare code for ACP when conducting advance care planning.

Function 5: Planned Care and Population Health

Planned care and population health focuses on organizing care delivery to meet the needs of the entire population. Evidence suggests that Americans receive only half of their needed preventive and chronic disease services, and that a team-based approach can provide proactive and timely access to appropriate preventive care, evidence-based management of chronic conditions, and improve patients' experience of care.[43]

Effective team-based care incorporates:

- Organized team structure
  - Link/empanel each patient to a practitioner and/or care team.
  - Define roles and responsibilities, making sure that each care team member is using his or her highest skills and abilities.
  - Reserve workspace and time to facilitate team interaction.
- Collaborative team functions
  - Establish huddles, protocols, and standing orders to create workflows to improve efficiencies in care.
  - Provide training opportunities for staff members to learn new tasks and improve coordination.
- Team culture that centers on quality improvement
  - Discuss routinely your practice data with your team to inform improvements in clinical quality, utilization, and patient experience of care.

Your practice should develop a team-based approach to understanding your patient population, and develop capabilities to measure quality of care, as well as using the data measured on the quality of care at both the practice and panel level to support action. To accomplish your population's health goals and to improve care so it is patient-centered, high-quality, and cost-effective for patients and families, you should focus on two change concepts:

- Use team-based care to meet patient needs efficiently.
- Proactively manage chronic and preventive care for empaneled patients.

A transformation to team-based care requires an investment, both in the time to develop new functions and to establish a new culture. However, once the initial investment is complete, the benefits of team-based care ensure its sustainability. Team-based approaches to care can achieve improved provider and care team satisfaction, improved team communication, improved patient safety, and improved patient and family engagement in care.[44]

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[43] Mitchell, P; Wynia, M; Golden, R; et al. (2012, October). Core Principles & Values of Effective Team-Based Health Care. Retrieved from https://nam.edu/wp-content/uploads/2015/06/VSRT-Team-Based-Care-Principles-Values.pdf

[44] Coleman, M. Dexter. D., & Nankivill, N. (2015, August). Factors affecting physician satisfaction and Wisconsin Medical Society strategies to drive change. *Wisconsin Medical Journal.* Retrieved from https://www.wisconsinmedicalsociety.org/professional/wmj/archives/volume-114-issue-4-august-2015/

Function 5 Requirements

Program Year 1 (2018 Starters)

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

Program Year 2 (2017 Starters)

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

Use team-based care to meet patient needs efficiently

Defining the change

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

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

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

Define roles and distribute tasks among care team members consistent with skills and abilities to better meet patient needs. Care teams consist of clinical and non-clinical staff who work together and take responsibility for delivering care to a specific panel of patients. In your team, each member plays an important role and works to the top of his or her skills and abilities, appropriately delegating tasks and communicating. The goal is to maximize the time practitioners have available for diagnosis, treatment, and building relationships with patients, while at the same time increasing job satisfaction and decreasing stress.[45]

Use a Swim Lane to Designate and Assess Care Team Roles and Responsibilities

In this video, Dr. Dom Dera from Ohio Family Practice Center explains how his practice uses a swim lane protocol to assess internal staff capabilities and assign roles and responsibilities.

To clearly delineate team roles and responsibilities, your practice should take the time to evaluate your current distribution of tasks and establish standard work procedures for optimal efficiency and effectiveness. It is also important for you to identify and add security and restriction points in your EHR, based on the role of the care team member.

As you continue to progress in CPC+, you will regularly reassess the roles on the care team and identify opportunities for expanded roles of care team members based on professional interests, changing needs of patient populations, and/or strategies to improve workflow and efficiencies in care delivery. Non-clinical staff can be included as key members of the care team by helping to accomplish routine tasks and clerical work, tracking referrals, conducting initial screenings to identify unmet social needs, and helping to understand patients' cultural and/or linguistic needs. For example, some practices have invested in additional training for their Medical Assistants (MAs) to serve as health coaches. As a health coach, the MA can provide continuous contact, support self-management, connect patients to community-based services, and provide cultural and linguistic support.

It is important to choose the right staff to support your patient population, including staff members who reflect your patient population (e.g., race, ethnicity, age).

Use team pre-visit planning and huddling to optimize preventive care and care team management of patients with chronic conditions. There are many strategies you can use to plan your patients' care, including huddles and pre-visit planning. Huddles can be used to plan for the day and typically last 10 to 20 minutes, depending on the structure of your practice. During huddles, your care teams can complete pre-visit prep work, and identify gaps in care, social needs, chronic disease management needs, screening alerts for preventive conditions, and patients with recent

Learn how CPC+ Practice, MidValley Family Practice builds team trust and communication using pre-huddles and end-of-the-day 15-minute huddles.

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

hospitalizations. The goal of huddles is to provide an opportunity to anticipate patient needs and prepare for changes in staffing and logistics so the day runs more smoothly. You can employ the EHR and other health IT data to identify the patients scheduled for the day, active diagnoses, risk stratification scores, and due and overdue services.[46]

Pre-visit planning is used to gather and organize information ahead of time, so the patient and practitioner can focus on interpreting, discussing, and responding to that information. Pre-visit planning starts at the end of the previous visit by planning ahead to the next visit (e.g., deciding next steps, planning any lab tests before the next appointment, scheduling the next follow-up visit). Before the next visit, a designated staff member reviews the patient's chart to collect pertinent information and test results, including following up on any results that have not been received (e.g., ensuring lab results and/or test results are in the patient record prior to the visit). For patients with more complex needs, you may decide to conduct pre-visit phone calls to review the agenda for the visit, discuss any special needs, conduct an in-depth medication review, and address any topics that will be helpful in preparing for the visit.[47]

CPC+ On Demand Video: Utilizing Pre-Visit Planning Tools and Teamwork. In this video, Providence Medical Group at Saint Vincent talks about the successful tools and strategies staff and providers use to prepare patients for visits.

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

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

[46] American Medical Association Steps Forward. (2015). Implementing a Daily Team Huddle. Retrieved from https://www.stepsforward.org/modules/team-huddles

[47] American Academy of Family Physicians. (2015, Nov-Dec). Putting Pre-Visit Planning into Practice. Retrieved from http://www.aafp.org/fpm/2015/1100/p34.html

Proactively manage chronic and preventive care for empaneled patients

Defining the change

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

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

Use data to proactively manage population health. First, identify the crucial measures in your practice that show gaps in care that provide opportunities for improvement. Try to focus your efforts on those measures that matter most to your patients' health, such as blood pressure control, tobacco use, and cancer screening. Avoid the temptation to focus on easily remediable process measures that might yield fewer longer term health gains. Based on your assessment, identify patients with chronic conditions or preventive services that need better monitoring. First, you should choose a specific condition or a preventive service that you want to improve in your practice (e.g., hypertension, cancer screening). You can then develop care delivery strategies to improve outcomes for this population of patients (e.g., standing orders, order sets, pick lists, SMS, shared decision making specific to these conditions).

You will also want to think about which metrics you can use to track your progress, such as measuring a process outcome (e.g., number of patients contacted to complete cancer screening) and a final outcome (e.g., number of patients completed cancer screening). These metrics will inform the success of your care delivery strategies, and practice improvements. Consider using your CPC+ eCQMs to inform your quality improvement strategy. You can use the established eCQM benchmarks as your goals for improvement.

Cost and utilization data should also be used to manage population health. There are a number of ways your practice can obtain cost and utilization data. Payer and shared savings reports are a great resource, as well as affiliated or partner hospital data. You may be able to derive these data from your EHR or other health IT software, Health Information Exchanges (HIEs), as well as state-specific tools. Your practice has access to the CPC+ Practice Feedback Report, which provides cost and utilization data for your attributed Medicare FFS beneficiaries who are connected to your CPC+ practice(s). In addition, you might consider requesting cost and utilization data from your top two or three payers, if you are not already receiving it.

Related Function 2 Health IT Requirements (Track 2 Only)

Produce and display eCQM results at the practice level to support continuous feedback

a. Enable the entire practice team to view eCQM results at the practice site level to support continuous feedback on quality improvement efforts.
b. Measure results should be updated as frequently as possible so that measures reflect current progress.
c. This capability should present results in a usable, actionable manner that the care team can use to effectively manage population health.

FAQ: What expenditure and utilization data are included in data feedback reports?

Answer: The current expenditure measures in the **CPC+ Practice Feedback Reports** *include total Medicare expenditures, acute inpatient stays, high-cost specialty care, your practice's primary care expenditures, and other practice primary care expenditures. The existing utilization measures include acute inpatient stays, inpatient discharges, ambulatory care sensitive condition (ACSC) discharges, ED visits, ED visits leading to hospitalizations, and observation stays leading to hospitalizations. The risk adjusted acute inpatient hospitalization and ED utilization measures used to calculate your CPC+ PBIP are also presented in the report. Additional measures and detail, such as diagnosis and facility information, will be added in future CPC+ Practice Feedback Reports*

Your practice can then establish an analytic process for improvement, such as investigating why a performance measures is below goal, planning a systematic approach to address the cause, and identifying process measures to monitor improvement. You can use data to identify gaps in care for your practice population.

Use condition-specific pathways of care. Interventions targeting specific populations of patients often require a planned, proactive approach. Your practice's care teams can establish disease-specific processes that incorporate evidence-based protocols and standing orders to guide treatment. Use of evidence-based proocols and clinical guidelines can increase quality of care and enhance health outcomes, help avoid errors and adverse events, and improve efficiency and provider and patient satisfaction. Health IT designed to improve clinical decision making can be particularly attractive for its ability to address the growing information overload

clinicians face, and to provide a platform for integrating evidence-based knowledge into care delivery.

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

Key Insights

Examples of Internal and External Data to Manage Population Health Patient Surveys

- Consumer Assessment Healthcare Providers and Systems (CAHPS)
- Patient-Reported Outcome Measures (PROMs)
- Internal patient satisfaction survey
- Registries
- Care guidelines
- Assessments
- eCQM reports
- Care delivery data (e.g., empanelment and risk stratification)
- Payer feedback reports
- Community health data

Learn how CPC+ practices Utica Park Clinic and PriMed Vandalia Family Practice created a culture of improvement.

Conduct regular care team meetings to review quality and cost data, and use the information to guide tactics to improve patient outcomes and value. Your practice can meet regularly to review and track your key data sources, which you can track over time to monitor your progress toward your goals on your quality measures, as well as your cost and utilization indicators.[48] You can begin by testing improvement strategies on a limited set of relevant measures, rather than working on all your performance measures at once. Your practice should engage the care team in meetings at least weekly to review practice- and panel-level data and identify patient-centered interventions to address causes for performance on utilization metrics and/or eCQMs. Your practice can continue to engage the care team in implementing iterative improvement tactics for interventions and targeting the root causes of lower-performing measures.

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

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Function 1: Access and Continuity

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Resource Articles

- How Primary Care Practices Can Improve Continuity of Care
- Defining and Measuring Interpersonal Continuity of Care

Please see Function 1, Appendix B for more resources such as guidelines, templates, and video clips.

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Resource Article

- Care Management: Implications for Medical Practice, Health Policy, and Health Services Research

Please see Function 2, Appendix B for more resources such as guidelines, templates, and video clips.

Function 3: Comprehensiveness and Coordination

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Resource Articles

- Core Competencies for Behavioral Health Practitioners Working in Primary Care
- Integrating Behavioral and Physical Health Care in the Real World: Early Lessons from Advancing Care Together

- Referral and Consultation Communication Between Primary Care and Specialist Physicians: Finding Common Ground
- Coordination Between Emergency and Primary Care Physicians
- Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanisms
- The High Concentration of U.S. Health Care Expenditures
- The Determinants of Health

Please see Function 3, Appendix B for more resources such as guidelines, templates, and video clips.

Function 4: Patient and Caregiver Engagement

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- Preference-Sensitive Care

Please see Function 4, Appendix B for more resources such as guidelines, templates, and video clips.

Function 5: Planned Care and Population Health

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Resource Article

- A Strategic Vision to Improve Value by Organizing Around Patients' Needs

Please see Function 5, Appendix B for more resources such as guidelines, templates, and video clips.

Driver 2. Use of Enhanced, Accountable Payment

Introduction

Driver 2 Requirements

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

The CPC+ enhanced payment structure helps support your practice's efforts to change how you deliver care and improve outcomes for your patients. You should understand what resources you need to make and sustain change. You will also need to track these new funds,[49] and strategically use these alternative payments to build or increase your capability to deliver comprehensive primary care in your practice.

CPC+ offers three payment elements to support and incentivize practices to better manage patients' health and to provide higher quality of care. The payment designs vary slightly for Track 1 and Track 2 CPC+ practices, and for practices participating in the Medicare Shared Savings Program. The three payment elements are the same for 2017 Starters and 2018 Starters and include:

- **Care management fee (CMF).** The CMF is a risk-adjusted, non-visit-based fee paid to both Track 1 and Track 2 practices to support augmented staffing and training aligned with the CPC+ care delivery transformation aims. These activities include improved care coordination, data-driven quality improvement activities, and targeted care management for patients identified as high risk.
- **Performance-based incentive payment (PBIP).** The PBIP encourages and rewards accountability for clinical quality, patient experience of care, and utilization measures that impact total cost of care. The PBIP is paid to practices prospectively to incentivize improvements. Your practice will be allowed to keep all or a portion of these funds if you meet annual performance targets. Practices dually participating in the Shared Savings Program do not receive a PBIP.
- **Comprehensive Primary Care Payment (CPCP).** The CPCP is paid to Track 2 practices as a lump sum quarterly payment based on historical FFS payment amounts designed to promote flexibility in support of comprehensive care. This "hybrid payment" allows practices to increase the depth and breadth of services provided and for population health improvement.

[49] Read details about CPC+ payments in the CPC+ Payment Methodologies Paper.

To accomplish your practice's goals using enhanced payment and to improve patient-centered, high-quality, cost-effective care for patients and families, you should focus on three change concepts:

- Use forecasting and accounting processes effectively to transform care and build capability to deliver comprehensive primary care.
- Align practice productivity metrics and compensation strategies with comprehensive primary care.
- Build the analytic capability required to improve care and lower costs for the practice population.

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

Defining the change

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

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

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

Invest revenue in priority areas for practice transformation. Your practice should strategically plan on how you will use the revenue for your care delivery transformation. Allocating revenue to high-priority areas can help to ensure long-term change. You may want to focus your initial **CMF payments** to augment staffing and training to provide historically non-billable and/or non-visit-based services, such as targeted care management to high-risk patients, SMS training, patient outreach and education, and coordination with other care

settings. These investments provide a strong foundation for your ongoing work in CPC+, better positioning your practice to continue building and enhancing your care delivery capabilities.

For standard participants in CPC+, PBIPs have no restrictions and can be used to fund needed care delivery resources. Note, however, that the PBIP is at risk for repayment in whole or part. Track 2 practices can use their CPCPs to support the time practitioners spend on the Comprehensive Primary Care Functions delivered through expanded visits or alternatives to traditional office visits for covered services. If you are a Track 2 practice, it will be critical to carefully plan how you will leverage the flexibility offered by this hybrid payment, especially as you grow the percentage of CPCP you receive as you progress in CPC+.

Use standardized accounting and budgeting tools and processes to allocate revenue. It is important that your practice maintain a budgeting process throughout your participation in CPC+ and monitor it regularly. Different practices use different tools and processes to gather historical data and make projections. Multiple options exist to building these capabilities. For example, you might use specific accounting tools or software for practice budgeting, or you could hire a financial consultant or institution. Alternatively, you might use an electronic spreadsheet.

Whatever option you choose, it is important to involve those responsible for making changes in your practice's care delivery in the budget process. Even if the finance department of an affiliated health system is responsible for your practice's budget, leadership in your practice should still be involved and kept informed about your budget process.

Furthermore, financial data should be part of your practice's regular data review, along with cost and utilization data, as well as quality and patient experience data. This broad capture of data is necessary to ensure allocated revenue is having the anticipated effect. For more information and details on use of CPC+ funds, please refer to the CPC+ Financial Reporting Guide and CPC+ Payment Policy Frequently Asked Questions.

CPC+ Expenditures Worksheet

This workbook can help your practice document and calculate the CPC+ expenditures you will report. You should modify it to suit your own practice's needs. **note:** You will not submit this workbook when you report expenditures in the CPC+ Practice Portal.

Key Insights

Integrating CPC+ into Your Financial Process

- Identify who will be responsible for budget process. Include all necessary personnel.
- Identify and engage in practice self-assessment, including against relevant data from external sources on the practice's performance.
- Use assessment and data, along with initiative requirements, to create priority areas for practice transformation.
- Allocate revenue after considering priority areas.
- Establish a budget process including accounting tools and a mechanism for monitoring predicted versus actual revenues and expenditures.
- Establish a monitoring process for reviewing outcome data and budget data to ensure that allocated resources are producing intended results.

FAQ: How will CMS use the information it collects through financial reporting?

Answer: CMS will use the financial reporting information to:

- *Understand how the resources provided through CPC+ are used to fund new and innovative types of work*
- *Identify which areas of work require the most support, which helps us improve the practice supports provided through CPC+*
- *Communicate about CPC+ at the regional or national level (using aggregated data only)*

Align practice productivity metrics and compensation strategies with comprehensive primary care

Defining the change

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

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

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

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

Develop compensation strategies that reward value and team-based care. Even as your practice engages in payment models rewarding value, volume most often defines practitioner

and team productivity and success. To achieve the aims of CPC+, you can test new approaches to compensating your team that better recognize and reward your care redesign while reflecting any new productivity measures. Diverse strategies are available to you, depending on your practice structure, ownership, and resources.[50] Your practice can use various tactics when aligning compensation for practitioners and staff with your practice transformation efforts.

You can start to increase motivation and buy-in by including your full team as you set common goals and benchmarks for clinical quality outcomes or process measures. You could also consider paying for process improvement work, sharing in profits and/or performance-based incentive payment earnings where everyone on the team receives a percentage, or awarding bonuses for meeting certain metrics. You can also use non-revenue incentives to motivate your team, such as training and education to develop skills or obtain certifications, flexible scheduling, work-from-home arrangements for certain tasks, or staff lunches to recognize and celebrate successes on meeting goals. We discuss use of data to drive continuous improvement at your practice more in Driver 3.

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

Defining the change

Analytic capability is the process of examining data sets to draw conclusions about the information they contain. This capability will help you track and respond to patterns in cost of care and health outcomes for your practice's patient population. Your continued use of this data will help you make ongoing decisions and prioritize necessary improvements in the practice.

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

There are multiple sources of data you can use, such as clinical quality data from your EHR, cost/utilization data from payers, and patient experience data. You have these data available within your practice and from external sources (e.g., CPC+ Practice Feedback Reports, data from payer partners). You may also have agreements with hospitals for admission and discharge data.

Once you identify a trend in your data, you will still need to drill down into patient level data to pinpoint the specific populations and characteristics of patients that are using services in similar patterns. You may need to expand your work with payers and your health IT vendor to create new reports that allow you to see this level of detail, and run and review these reports on a

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

regular basis to identify trends in cost and outcomes. Key tactics related to building your practice's analytic capability are summarized in the Change Tactics table.

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

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

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

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

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

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

Key Insights

Steps to Investing in Care Transformation

- Identify priority areas for investment in practice changes and service delivery through self-assessment including data from relevant sources.
- Focus initial investments on building capacity for future change.
- Work with your teams to ensure revenue and resources are allocated appropriately to identified priority areas.
- Monitor priorities and progress to goal using process, outcome and balance measures.

References and Resource Articles

References

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Resource Article

- Guidance for Structuring Team-Based Incentives in Health Care

Please see Driver 2, Appendix B for more resources such as guidelines, templates, and video clips.

Driver 3: Continuous Improvement Driven by Data

Introduction

Continuous improvement driven by data refers to using measurement to guide your practice's transformation work. As part of this transformation, you are developing ways to reliably and systematically incorporate data on quality and other metrics at the practice level and panel/care team level. By looking at data at the practice level, you can understand how all members of the practice impact quality of care and how you compare with similar practices. By measuring at the panel or care team level, your team(s) can fine tune workflows and identify new areas to target for improvement. This effort requires active and engaged leadership, committed team members with improvement skills, the allocation of time and resources for practice change, and a practice culture of improvement.

There are many types of data available to your practice for use in improvement, from both external sources (e.g., payers, Health Information Exchanges [HIEs]) and your internal systems (e.g., electronic clinical quality measures [eCQMs], scheduling data). During PY 2018, your practice will continue to work with your health IT vendor to ensure you have the ability to generate meaningful data to make decisions and track progress toward improvements in care at the patient, panel, and practice level. To assess quality performance and eligibility for the CPC+ performance-based incentive payment (PBIP), CPC+ requires your practice to report eCQMs annually at the practice site level. Internally, you should generate quality measure reports both at the practice and panel/care team level.

In addition to your eCQM data, your practice receives utilization and expenditure data from CPC+ payers to understand patterns of care for your patients, and how changes at your practice impact both quality and expenditures. It is critical to build your capability for internal measurement and review and to involve all practice staff in the regular use of data to guide your practice transformation efforts.

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

- Measure and improve quality at the practice and panel level.
- Ensure full engagement of clinical and administrative leadership in practice improvement.
- Adopt a formal model for quality improvement and create a culture in which all staff members actively participate in improvement activities.
- Actively participate in shared learning.

Use of CPC+ Practice Feedback Reports

Data is a foundational tool to help practices measure progress, track change, and identify areas for quality improvement and shared learning. As a CPC+ practice, you will use data from multiple sources to inform your CPC+ activities. To support your work, CMS provides claims-based data feedback on your CPC+-attributed Medicare FFS beneficiaries in the form of quarterly reports. CPC+ payer partners also agree to share comparable levels of data to CPC+ practices. Data included in the CPC+ Practice Feedback Reports include:

- Descriptive information about your practice and your practice's attributed beneficiaries
- Medicare claims-based information shown by practice and region, including expenditure and utilization measures
- Care delivery performance highlights
- National, regional, and practice trends

Table 1 shows the scheduled release dates for the CPC+ Practice Feedback Reports in PY 2018. For the beginning of 2018, reports can be downloaded in the **Reports** tab of the CPC+ Practice Portal. We anticipate transitioning the Excel-based Practice Feedback Reports to an interactive, online tool within the CPC+ Practice Portal, currently scheduled for launch in mid-2018. Please stay tuned for more details on the new online data feedback tool later this year.

Table 1. 2018 Medicare Data Feedback Report Schedule

Report	Claims Period	Scheduled Release Date
Report 4	Q3: Jul – Sept 2017	End of January 2018
Report 5	Q4: Oct – Dec 2017	End of April 2018
Report 6	Q1: Jan – Mar 2018	End of July* 2018
Report 7	Q2: Apr – Jun 2018	End of October 2018
Report 8	Q3: Jul – Sept 2018	End of January 2019

** tentative launch of online tool*

Future CPC+ Practice Feedback Reports will continue to build on previous versions, including integrating new measures, data sources, and a more interactive format as the project progresses. Practice staff can use the Practice Feedback Reports to drive transformation by measuring and tracking progress toward practice improvements, as well as developing processes for acting on key performance data.

You can learn more about how to use your Practice Feedback Reports by watching the most current on-demand webinars and by referencing the User Guide for Practice Feedback Reports on CPC+ Connect (updated sessions and guides are provided with each quarter's Practice Feedback Report). If you are interested in helping give regular feedback on these reports and

providing details on how your practice uses these data, CMS will provide information on how to give feedback at a later date.

Other CPC+ payer partners will send you data feedback specific to their attributed patients separately, and may use different methods, timelines, and formats for their reports. In some regions, CPC+ payers may collaborate to create a unified report that includes information for all of your CPC+-attributed patients.

In addition to these reports, CMS is exploring ways to deliver regular claims and claims-line feed files to practices that have the technical ability to receive and analyze these data files. We will provide more details on how to request and receive these data in 2018.

Measure and improve quality at the practice and panel level

Defining the change

Collecting the right data allows you to quantify the problem you are trying to address. You can use data to describe how big, how much, how often, how many, and what type of issues your practice and patient population are facing. Gathering data for analysis is only the first step in improvement. Making progress involves evaluating these data against practice, panel, and/or care team goals, and establishing an analytic process to use data to identify root causes of performance and define improvement interventions. Key tactics related to measuring and improving quality at the practice and panel level are summarized in the Change Tactics table.

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

As you become more familiar with gathering useful data for analysis, develop ways to present the data to your team in an actionable format. As you move forward in CPC+, you might need to train additional practice staff on how to read and interpret panel- and practice-level data to fully engage them in practice improvements.

Identify a set of EHR-derived measures useful for your patient population. The EHR is a good source of data when you are deciding where to begin and what to measure and improve. Evaluating eCQMs and utilization measures will help you identify those areas that need improvement, as well as those that will be most meaningful for the practice and most beneficial for the patients.

Improving Quality Through eCQM Checklists and Patient Outreach

This CPC+ practice spotlight highlights the work of Stillwater Medical Physicians Clinic on using structured eCQM documentation workflow to improve performance.

Your practice should focus on reports that are meaningful to the practice team and address your needs. Prioritize quality measures that the practice team deems important as an area of focus. For example, when a practice desires to focus on the care of its patient population with diabetes, process and outcome measures related to this goal may be included to provide a more complete picture of those areas needing improvement.

Keep in mind that your EHR may have many more reports available than are useful to your practice. Deliberate use of data can be better than using more data to achieve improvement efforts.

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

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

Consider displaying your data in graphs to allow everyone to have a visual representation of the data. Including your goals and benchmarks in the graph will help everyone readily see progress towards these marks. Many practices in CPC+ have found run charts to be a useful tool for visualizing progress. A run chart is a plot of data for a given measure over time; these data form a type of line graph. This type of display allows everyone, leadership and team alike, to have a visual representation of the data. You can include the benchmarks in the graphic representation to help everyone visualize performance against this mark.

IHI Run Chart Tool
This resource offers a guide to run charts and a template for practice use.

Use relevant data sources to create benchmarks and goals. Consider using internal (e.g., information from an ongoing test of change) and external (e.g., payer reports) data to create benchmarks and set goals to guide improvement. Remember, your PBIP retained is calculated using benchmark performance thresholds, which you can use to track your performance (see pages 46–53 in the PY 2018 CPC+ Payment Methodologies document for detailed information on benchmarking in CPC+). Data from within your practice will assist you in establishing a baseline and monitoring progress toward goals.

Internal goals may be set at the panel level. Panel-level data showing progress towards your practice goals helps the members of your team understand how they each affect achievement of the overall practice goal on any given measure.

Key Insights

Optimizing eCQM Data

- Run reports on all relevant clinical quality and utilization measures from the practice EHR.
- Always gather raw data. Summary and aggregate data may not answer all the questions.
- Create reports at both the practice and the panel level (care team).
- Prioritize quality measures that the practice team deems important as an area of focus.
- Develop a workflow to ensure the team enters non-electronic data (i.e., faxes) into the EHR in correct, discrete data fields.
- Study internal and external data to establish goals and benchmarks.

External data allow you to compare your practice against similar practices in the community, state, or region. External data include cost and utilization reports from CMS and CPC+ payer partners. Some of these reports contain benchmarks that are useful for helping your practice set goals for quality improvement. Benchmarks are most meaningful when derived from similar practices or environments.

FAQ: What are the purpose and intent of CMS' benchmarks?

Answer: Practice performance is measured against absolute performance thresholds. The minimum and maximum thresholds are determined from a benchmark population external to CPC+ participation.

In turn, your practice site's own performance relative to this benchmark determines the incentive amount your practice site retains. Your practice site is not scored on a relative-performance basis, nor is the size of the payment your practice retains determined by performance of your peers. The intent of the external benchmarks is to reward practices for reporting challenging measures, even when actual measure performance has opportunity for improvement.

Ensure full engagement of clinical and administrative leadership in practice improvement

Defining the change

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

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

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

Make practice change a component of clinical and administrative leadership roles. Creating a comprehensive primary care practice is a paradigm shift requiring strong leadership support to meet the CPC+ aims of more patient-centered, high-quality, and cost-effective care. Everyone from leadership to administrative and clinical staff must be on board to effect change. It is the primary responsibility of leaders to build the will to change, but every member of the practice team must embrace the vision of practice transformation. Leaders provide the vision and must then communicate that vision to all practice staff. Both clinical and administrative leaders should provide guidance, training, insight, mentoring, coaching, and inspiration across all practice staff. Quality, utilization, patient experience, and cost metrics can be included as evaluative tools for leaders to increase accountability for practice goals.

Building a Transformation Culture to Sustain Change

This CPC practice spotlight highlights the work of Providence Medical Group in Dayton, Ohio, on creating a culture of improvement that includes a standard approach to change, staff engagement and learning opportunities, and the use of data.

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

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

Defining the change

A quality improvement model provides a framework to systematically improve the way care is delivered to patients.[51] By identifying a formal model for quality improvement, your practice will have a process for using data to identify opportunities for change and assessing whether the changes you are making in your practice result in improvement in care and cost. As you research the various models, think about what will work best for your practice. There are several models to choose from; examples include:

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

- The Model for Improvement ("Plan-Do-Study-Act" [PDSA])
- Six Sigma
- LEAN
- Analytics Adoption Model

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

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

Integrate practice change/quality improvement into staff duties. Successful improvement strategies leverage the knowledge, expertise, and skills of the people in your practice. Quality improvement is not just another task to accomplish; it is everyone's job and every member of the team is important.

Engage all staff in identifying and testing practice changes. Every member of your practice plays a critical role in identifying areas for improvement. The practice team, especially the members identifying the potential change, should take part in planning for change and documenting the progress and outcomes. Part of planning for change is acknowledging current reality, and how to get from current reality to the change and, ultimately, the practice's vision. You should also acknowledge what can and cannot be done to get there, and focus on strategies that are possible to test and implement by practice staff.

Key Insights

Strategies to Increasing Staff Engagement

- Set aside time for regular team meetings to discuss practice improvements and celebrate achievements.
- Engage everyone in the practice in change efforts. Consider ideas for improvement from all members of the practice team and involve them in developing the plans for change.
- Hold leadership accountable for practice improvements.
- Allocate time for improvement activities.
- Involve staff in iterating and monitoring changes as they evolve.
- Ensure everyone has a firm understanding of how improvement efforts are affecting overall results.

Designate regular team meetings to review data and plan improvement cycles. Consider scheduling meetings to occur on a pre-determined schedule at a time that allows

as many staff as possible to attend (e.g., over lunch, before the day begins) and send out any data in advance of the meeting to allow staff time to review.

Promote transparency and accelerate improvement by sharing data with staff. When your teams participate in improvement projects, they are able to see the results of their work. Sharing the data with the entire team will show how team members' actions affect the results and will increase their ownership of the work. Shared data will also stimulate additional ideas for the team to plan improvement cycles.

Promote transparency and engage patients and families by sharing practice-level quality of care, patient experience, population health, and utilization data with patients and families. Similar to engaging your team with the results of your work, engaging patients and families also shows them the positive impact that you are making on their care. Sharing data with patients and promoting transparency and engagement shows that patients and families are the center of all your care transformation activities. This is a way to also demonstrate the value of their contributions and provide you with ideas for continuous improvement, which can be done through a Patient and Family Advisory Council (PFAC).

Actively participate in shared learning

Defining the change

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

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

The CPC+ learning community offers opportunities to practices to share and learn from each other, including national conferences and webinars, spotlights, Practices In Action, Action Groups, Affinity Groups, Regional Learning Sessions, the CPC+ Connect site, as well as informal exchanges and facilitated groups in your region. Key tactics related to actively participating in shared learning are summarized in the Change Tactics table.

Practices are encouraged to provide time for multi-disciplinary staff to engage in shared learning opportunities. You might find it helpful to explore all learning activities offered and as a team determine what topics and which staff member(s) are best suited as subject matter experts or active learners who will be responsible for conveying lessons learned to the rest of your team.

In particular, we recommend identifying a Practice/Learning Lead and Clinical Champion for each improvement effort. The Practice/Learning Lead will evaluate needs and determine priorities, and will ultimately be responsible for the effort. The Clinical Champion will lead change efforts, provide feedback, and communicate changes to clinical teams and care managers who are implementing them. Always consider those directly involved in implementing the change, and whose work processes will change.

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

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

Access available expertise to assist in practice changes. CPC+ practices need knowledge about what to do and how to do it to make process improvements. Active participation in the CPC+ learning community promotes the exchange of ideas with your peers in other practices regarding improvement approaches, progress tracking, results obtained, successes, and lessons learned. Engagement with other CPC+ practices can help you avoid barriers, address challenges sooner, and accelerate the pace of change in your practice.

References

- Blumenthal, D.M., Song, Z., Jena, A.B., & Ferris, T. (2014, April 13). Guidance for Structuring Team-Based Incentives in Health Care. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3984877/
- Module 4. Approaches to Quality Improvement. (2013, May). Retrieved from https://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod4.html

Please see Driver 3, Appendix B for more resources such as guidelines, templates, and video clips.

Driver 4: Optimal Use of Health IT

Introduction

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

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

Know the certified health IT requirements for your track.

Appendix D details the health IT requirements by track, Appendix E details the CPC+ health IT definitions, and Appendix F includes the CPC+ health IT policies and procedures for participating practices. You should become familiar with these requirements. This section highlights aspects from these references to corresponding details in the appendices. As outlined in Appendix D, CPC+ practices must use technology that meets the certified health IT definition defined in the Quality Payment Program, and must maintain its use throughout all five CPC+ program years.

Check your CMS EHR Certification ID.

You can find detailed information on all 2014 and 2015 Edition certification criteria, companion guides, and test procedures on the Testing and Test Methods page of the Office of the National Coordinator (ONC) HealthIT.gov website. The (c)(1)-(4) criteria for clinical quality measure (CQM) reporting are listed below.

- § 170.315(c)(1): CQMs – record and export (Companion Guide)
- § 170.315(c)(2); CQMs – import and calculate (Companion Guide)
- § 170.315(c)(3): CQMs – report (Companion Guide)
- § 170.315(c)(4): CQMs – filter (Companion Guide)

Track 2 practices have requirements for advanced health IT functions, including:

- Risk stratify practice site patient population; identify and flag patients with complex needs (no later than July 1 of Program Year 2).
- Produce and display eCQM results at the practice level to support continuous feedback (no later than July 1 of Program Year 2).
- Empanel patients to the practice site care team (no later than July 1 of Program Year 2).

Risk Stratification

Read about how CPC+ practice SAMA Healthcare from El Dorado, Arizona, used the risk stratification capability of its EHR and blended it with care management to improve preventive care services.

- Systematically assess patients' psychosocial needs and inventory resources and supports to meet those needs (no later than January 1 of Program Year 3; practices must adopt health IT certified to the 2015 Edition "Social, Behavioral, and Psychological Data" criterion found at 45 CFR 170.315(a)(15)).
- Establish a patient-focused care plan to guide care management (no later than January 1 of Program Year 3; practices must adopt health IT certified to the 2015 Edition "Care Plan" criterion found at 45 CFR 170(b)(9).
- Document and track patient reported outcomes (timeline to be specified by CMS at a later date).

Your practice has the option of using multiple health IT vendors to meet these requirements. All vendors being used to support Track 2 requirements must sign a Letter of Support that attests the vendors will support practices in developing and implementing advanced health IT functions.

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

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

Use Office of the National Coordinator (ONC) certified health IT

Defining the change

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

CPC+ requires the use of certified health IT in both Track 1 and Track 2 to perform specific functions throughout all five CPC+ program years. You need to know your certified health IT version to determine the need for updates. All certified health IT vendors are listed on the Certified Health IT Product List (CHPL) website. These vendors work with approved testing bodies for their certification testing. The CHPL website is updated almost daily to reflect the most up-to-date list of certified health IT vendors. You can search by developer, product, or testing body, with filters for certification status, certification edition, and certification criteria. Details for each product include the specific certification criteria each vendor product is certified to and the vendor CMS Certification ID, as well as the eCQM version and to which criteria it has been certified. Key tactics related to use of ONC-certified health IT are summarized in the Change Tactics table.

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

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

Health IT transitions. Prior to moving forward with health IT transition, practices should review prerequisite materials and be familiar with CPC+ health IT requirements. Every CPC+ practice must use technology that meets the CEHRT definition finalized for the Quality Payment Program. As stated in the CPC+ Health IT Policies and Procedures (Appendix F), practices in Track 2 may switch to a different vendor if a vendor withdraws support for a specific health IT function, or if the practice decides it wants to work with a different vendor. However, the new vendor will also need to commit to supporting the practice for one or more of the specific health IT functions originally listed in the CPC+ Request for Applications and will be asked to sign an

MOU with CMS. Practices must have vendor support for all health IT functions listed to remain in CPC+.

Transitioning health IT vendors is a major undertaking for your practice. Ideally, both your current (legacy) vendor and new health IT vendor should provide your practice with resources to help ensure the transition is a success. CPC+ requirements, and how to remain in compliance with them during the transition, should be part of ongoing communication with your new health IT vendor.

The 2017 Health IT Transition Guide provides a systematic walkthrough of the process of switching health IT vendors. It includes:

- A review of the CPC+ track-specific health IT requirements
- Transition timeline considerations and options
- The planning process, including selecting a new health IT vendor and assembling a transition team
- The process for developing a risk management plan and a rigorous quality assurance process
- Approaches for confirming that your transition was a success

FAQ: Are practices required to be on one health IT vendor for at least nine months during the measurement period?

Answer: No, CPC+ practices are not required to use one health IT vendor for a set time period. CPC+ practices must consider the timing of any health IT vendor transition as it may impact their ability to report on the CPC+ eCQMs.

Throughout the process, good communication with your health IT vendor(s) is key. The guide includes a companion workbook, 2017 CPC+ Health IT Transition Workbook, which includes customizable templates your practice can use to get started, manage, and document your transition, and to develop and implement risk management and quality assurance plans.

If your practice opts to switch health IT systems during CPC+, you must notify CMS at CPCPlus@Telligen.com as early as possible. In the e-mail to CPC+ Support, use the subject line of [Change of Health IT Vendor]. You will then be referred to the Health IT and Quality team, which will help you through the entire process. CMS will review each request for health IT vendor transition. You will need to develop a comprehensive plan for CMS review and approval as part of your transition. If the switch will result in the inability to report 12 months of data from the new system, CMS may approve an alternative submission plan.

Note: If your practice fails to give notice in a timely manner and is not able to report the required eCQM data, you risk removal from CPC+. Please carefully review the policy outlined in Appendix F.

Maintain and expand practice capacity for the optimal use of health IT

Defining the change

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

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

It takes time to leverage the investment you have made in your health IT to optimize practice workflow in an effort to automate tasks. You can use automated alerts to notify team members when patients have preventive screenings due or when they are overdue for labs. Patient portals can reduce incoming phone calls by transferring patient communications to a more efficient communication channel. For example, your practice might replace paper or spreadsheet registries for patients with diabetes with an automated population health report from your health IT system. The automated report reduces workload on the front end (gathering the data) and back end (identifying gaps of care). You should think about how to best align practice workflows to make optimal use of your practice's health IT system.

Convene regularly to discuss and improve workflows to optimize use of health IT. As you continue to explore ways to optimize health IT for specific workflows, you may want to consider expanding your use of workgroups that include end users. Practices can convene workgroups in a rapid-cycle manner to address required workflows. For example, a practice may have consistent workflows for screening for tobacco use, but no place to document cessation intervention. A workgroup can help identify if addressing that gap should be done as part of physician or advanced practice nurse practitioner documentation, nursing documentation, or some other workflow. Based on how your practice wants to manage this change, the workgroup can help shape

Key Insights

Strategies to Expand Capacity for Health IT

- Map all practice workflows involving health IT touchpoints and review with all staff.
- Develop workflow diagrams that define the process for data entry or extraction.
- Update diagrams anytime workflows change.
- Develop discrete data fields crucial to effectively using health IT for patient care, reporting, and evaluation.

requirements for the health IT vendor on what the expected functionality should be of your technology.

Engage regularly with health IT vendors, including through ongoing participation in CPC+ Affinity Groups. You are encouraged to join the CPC+ Affinity Groups on CPC+ Connect, which are designed to offer support, best-practice sharing, and peer-to-peer learning for health IT-related reporting and strategy. CPC+ Affinity Groups provide a forum to share your change experiences, ideas, challenges, and solutions with other practices that are using the same health IT solution, as well as vendor representatives who can assist with technical solutions. A subset of online groups will also have live web meetings to further support the community. There are two types of Affinity Groups that will have live meetings: **Collaborative Affinity Groups** and **Capability Affinity Groups**. Vendors are invited to be part of these groups. These two types of Affinity Groups will serve different purposes.

- **Collaboration Affinity Meetings.** Practices collaborate to share experiences, resources, and solutions in utilizing health IT for comprehensive primary care, typically in a panel format. These meetings are designed to allow practices to hear from multiple peers and understand various approaches to solving the same challenge.
- **Capability Affinity Meetings.** Practices work with health IT vendors to identify gaps and elicit business requirements for health IT capabilities to meet the Track 1 and Track 2 enhanced health IT requirements. Capability meetings typically include a vendor-led instructional portion of the agenda and a practice presenter to share the vendor's strategy in action.

FAQ: May we use our CMS care management fees (CMFs) to pay for health IT purchases, upgrades, or eHealth devices?

Answer: No. You may not use Medicare fee-for-service (FFS) CMFs paid by CMS to pay for health IT/software, upgrades, modules, eHealth devices, or monitoring equipment. The use of Medicare FFS CMFs on any kind of health IT is prohibited.

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

Personnel responsible for managing health IT need not be IT specialists by trade, but should have a high aptitude for learning this task. In the office-based setting, this responsibility may fall to a clinically trained individual with a strong knowledgebase, skill set, and interest in health IT. The champion(s) need to have direct access to the health IT vendor representative, be included in regular meetings with the vendor, and serve as a clinical subject matter expert when new workflows are being developed. This access helps your health IT vendor develop the functional

and IT requirements you need to support your practice changes. It is important to create open communications with the vendor to understand timeframes for delivery and the change request process, as well as how best to request enhancements for new functionality. Being included in the development process gives champions the background and context to explain to their peers why certain decisions were made in workflow changes.

Cross-train staff in key skills in the use of health IT to improve care. Every member of the practice team must interface with health IT at some point during the workday, whether for documentation of patient care, patient outreach, care management, billing, registry monitoring, and/or data tracking and measurement. Cross-training team members in key skills spreads the workload and responsibility for supporting your health IT infrastructure. It also ensures that progress never comes to a halt when team members are unavailable.

Key Insights

Increasing Staff Engagement in Health IT

- Provide cross-training for data entry and review of records.
- Increase the skill set of cross-trained employees to add to the efficiency of the practice.
- Provide cross-training to enhance teamwork and increase team satisfaction.
- Update training annually and any time health IT changes.
- Provide opportunities for hands-on activities with health IT during training.

Enable the exchange of patient information to support care

Defining the change

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

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

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

Develop information exchange processes with other service practitioners with which your practice shares patients. Sharing patient health information with other providers (e.g., specialists) who care for your patients reduces duplication of services and tests while also enhancing the quality of care delivered across the medical neighborhood. Health IT can provide a more effective way of making patient referrals and exchanging clinical health care data with specialists and other providers. Assess what health IT these other practices have in place, if it is similar to your health IT, and what patient data you can share with each other to facilitate care coordination and continuity of care. Your collaborative care agreements should include ways you plan to communicate with the specialists who provide care to your patients, including through the use of secure messaging and/or use of other health IT tools when available.

Use standard documents created in your health IT (e.g., referral or care transition templates with standard elements). Sharing documents electronically with other providers is not always possible, but you can still use health IT to communicate effectively. Creating standard documents and extracting data directly from the health IT system to populate documents you share with other providers is the most accurate method of conveying information about your patients. Work with your collaborating specialists and organizations (e.g., home health, skilled care facilities) to develop a standardized response document derived from their health IT system. Work with your health IT vendors to determine what templates are available as part of the software or as modules, then discuss how to modify the standardized documents to fit your needs or build into your workflow.

Use non-clinical workflows to enter external structured clinical data into health IT. Work with your health IT vendor on clinical document architecture (CDA) content. The CDA is a document standard developed by the Health Level 7 (HL7®) organization, which specifies the structure and semantics of clinical documents for health care data exchange. Numerous HL7 guides have been released, including those for clinical notes, medication therapy management, and personal advance care plans. You should work with your health IT vendor on CDA content to ensure it contains content of value to the practice and your referring practitioners, including details for ONC-required data standards (e.g., Systematized Nomenclature of Medicine Clinical Terms [SNOMED CT], Logical Observation Identifiers Names and Codes [LOINC]).

Measure and report practice- and panel-level eCQMs from certified health IT

Defining the change

Quality measurement and improvement is a key component of practice transformation in CPC+. Your practices is expected to select and successfully report 9 of the 19 measures from the CPC+ eCQM set (both outcome measures and 7 of the remaining 17 measures). Although you are required to report only nine measures, we suggest you

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

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

For details on quality reporting requirements, including how to implement practice- and panel-level reporting of eCQMs, refer to Section III, Quality Measurement and Reporting, of this Guide.

Driver 5: Aligned Payment Reform

Introduction

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

Payers signed a Memorandum of Understanding (MOU) with CMS that outlines their commitment to strengthening primary care through care transformation. As stated within the MOU, payers will regularly share cost, utilization, and quality data with practices, which enhances practices' ability to manage their patient population's health. Payers will also contribute to a learning community that will lead the nation's efforts to transform health care and leverage the potential of public-private partnerships. The scope of the MOU includes the payers' commitment to non-visit-based financial support to CPC+ practices, data sharing with CPC+ practices, quality measure alignment with CPC+ practices, and developing a common approach towards care delivery requirements and accountability toward CPC+ practices. Globally, the MOU commits the payers to participating in CPC+ and providing reports to CMS for monitoring and evaluation.

Payers will support CPC+ practices in both tracks. All payers (including CMS) will enter into agreements with the participating practices. As in the case of CMS, these may be new contracts, or they may be existing contracts with practices that are aligned with the CMS approach. Please contact your payer partners to confirm whether an existing agreement is considered aligned with CPC+. Payers may consider focusing on these four change concepts:

- Use population-based payments to supplement FFS payments for comprehensive primary care services.
- Provide actionable and timely cost and utilization data to practices.
- Reward practice actions to reduce the total cost of care through an incentive payment.
- Align quality measures.

Use population-based payments to supplement FFS payments for comprehensive primary care services

Defining the change

CPC+ payers will attribute their beneficiaries to a primary care practitioner and share their attribution methodology with CMS. Attribution results in greater concentration of costs for attributed patients within CPC+ practices, increasing the practices' ability to reduce costs. Payers will pay practices a monthly supplemental per-member, per-month (PMPM) fee that may be based on a chosen risk adjustment methodology. Risk methodologies will vary from payer to payer, but should align with the CPC+ payment model and support purchase of the Comprehensive Primary Care Services.

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

Throughout, CPC+ payer partners will continue their efforts to align payment and measurement strategies, including a shift from FFS payment to comprehensive payments, allowing practices more flexibility to provide comprehensive care outside traditional office visits. Key tactics related to using population-based payments are summarized in the Change Tactics table.

Prospectively align every member or beneficiary with a primary care practitioner, care team, or practice. Through the process of empanelment, practices align their patients with a specific practitioner or care team. Payers use a similar process to align their beneficiaries with practitioners, but call it attribution. Through the process of attribution and risk stratification, payers can distribute care management fees more appropriately. You should review the data provided by your payer partners in CPC+, especially panel reports, to understand which patients have been aligned to you and the risk profile assigned to these patients by the payer. After establishing a feedback loop for practices to communicate with payers, you should continue to provide clarifying information to one another and answer questions about assigned patients.

Use a risk-adjusted per-member per month (PMPM) payment to supplement FFS payments. CPC+ was designed to include a risk-adjusted PMPM payment to allow practices to hire critical personnel like care managers, better manage patient populations, provide more proactive care, and make investments in care delivery improvements to achieve the Comprehensive Primary Care Functions. Throughout CPC+, you should stay informed of your payer partners' processes for disseminating these payments and understand the methodologies used for assigning risk collaboratively align standards for comprehensive primary care services.

You should be knowledgeable of basic coding processes and risk-scoring methods to ensure you are adequately describing the level of severity for each patient when submitting claims. The risk-scoring methodology used by payers will be different from the risk stratification process you use to identify and target care management services to patients whom the team believes to be at high risk and amenable to longitudinal care management.

Provide actionable and timely cost and utilization data to practices

Defining the change

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

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

Provide at least quarterly reports of data regarding services (i.e., ED visits, hospital admissions/discharges) received by beneficiaries outside of the primary care practice. Data resources are a critical piece of practice transformation and are necessary to drive improvements at the patient, panel, and practice level. Although claims-based data are not always the most timely source of data, many practices are using payer reports to understand how patients are accessing care, especially hospital, emergency, and specialty care. CMS provides data to all practices on cost, quality, and utilization, based on Medicare claims, through quarterly Practice Feedback Reports. In 2018, practices in some regions will start to receive data reports that include aggregated information across other payer partners. Continuous monitoring of these data every quarter will help you identify areas of opportunity for changing workflow and processes at the practice and system levels. These data resources will also allow you to identify trends in performance and help you determine if you are focusing your efforts in the right direction.

Key Insights

Using Payer Data to Guide Improvements

- Identify key staff responsible for downloading and reviewing Practice Feedback Reports each quarter.
- Use multiple sources of payer data to inform improvement efforts.
- Be transparent with data across the practice and with collaborating providers outside the practice.
- View data over time. Trends in data are more valuable than single data points.

Reward practice actions to reduce the total cost of care through an incentive payment

Defining the change

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

CMS will prospectively pay and retrospectively reconcile a performance-based incentive payment (PBIP) based on how well the practice performs on patient experience measures, clinical quality measures, and utilization measures that drive total cost of care**. Similarly, other CPC+ payers should use financial incentives to reward practices' achievement of improved health outcomes, quality, and/or costs.** Key tactics related to rewarding practice actions to reduce total cost of care through a PBIP are summarized in the Change Tactics table.

Align quality measures

Defining the change

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

To the greatest extent possible, **CPC+ payers should align practice quality and performance measures with those participating in CPC+. CPC+ uses eCQMs, patient experience of care measures, utilization measures, and Patient-Reported Outcome Measures (PROMs) to track experience and quality of care, identify gaps in care, and focus quality improvement activities.** CPC+ payers will provide practices with practice- and patient-level data to be used for monitoring and evaluation purposes. A key tactic related to aligning quality measures are summarized in the Change Tactics table.

To reduce CPC+ practices' administrative burden, the goals is to limit the total number of measures you need to report across all payers. Practices regularly report that keeping up with different measures for each insurance company is burdensome. Consistency of measures and definitions supports regional alignment of the transformation work in the community. There is synergy when multiple members of the medical neighborhood work together to improve a specific quality measure. Whenever possible, we recommend you align your overall quality improvement efforts across payers and other programs you participate in to create efficiencies and optimize practice investments.

CPC+ Change Package

Introduction

The CPC+ Change Package provides a summary of key drivers, change concepts, and change tactics described in Section I that contribute to the overall CPC+ aims of more patient-centered, high-quality, and cost-effective care. This resource includes a diverse set of ideas that can be helpful in guiding your care delivery work. Whether your practice is just beginning your care redesign or is further along, the Change Package provides you a summary of high-impact changes your practice can implement to achieve success in CPC+. The CPC+ Change Package is also listed as the first key CPC+ resource in Appendix A, which provides a link back to this section for quick reference.

DRIVER 1: Five Comprehensive Primary Care Functions

FUNCTION 1: Access and Continuity

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

Table 2: Access and Continuity Change Concepts and Tactics

Function	Change Concept	Change Tactic
1 Access and Continuity	**A. Empanel all patients to a practitioner and/or care team**	1. Assign responsibility for the total population, linking each patient to a practitioner and/or care team.
	B. Ensure timely access to care	1. Provide 24/7 access, guided by the medical record, to the practitioner and/or care team for advice and information to guide urgent and emergent care.
		2. Use a patient portal and secure messaging to provide access to health information.
		3. Provide office hours in early mornings, evenings, and weekends with access to the patient medical record.

Function	Change Concept	Change Tactic
		4. Provide same-day or next-day access to the patient's own practitioner and/or care team for urgent care or transition management
		5. Use alternatives for care outside of the traditional office visit to increase access to care team and practitioner, such as e-visits, phone visits, group visits, home visits, and visits in alternate locations (e.g., senior centers, assisted living centers) captured in the medical record.
	C. Optimize continuity with practitioner and/or care team	1. Document all care provided in the practice in the same electronic health record.
		2. Measure care continuity between patient and practitioner and/or care team.
Access and Continuity Requirements	See CPC+ Care Delivery Requirements in Appendix C	

FUNCTION 2: Care Management

Care management for high-risk, high-need patients is a hallmark of comprehensive primary care. Your practice should focus its care management resources on two cohorts of patients who are likely to benefit from this intensive resource: patients requiring proactive, relationship-based (longitudinal) care management and those otherwise stable patients who require short-term, problem-oriented (episodic) care management.

To identify these two cohorts of patients, your practice will use a systematic approach to risk stratify the entire practice population, and to identify those patients at increased risk and those most likely to benefit from targeted, proactive, relationship-based (longitudinal) care management. Practices use event triggers (e.g., hospital discharges and other transition of care, new diagnosis of major illness) to identify patients for episodic (short-term) care management, regardless of risk status.

Data from CMS and other payers as well as from the EHR, complemented by clinical judgment and the care team's knowledge of the patient, will guide your practice's risk stratification process. Care management is targeted, fully integrated into the primary care practice, and guided by a patient-centered plan, focusing on what your patients need to meet their health goals.

Table 3: Care Management Change Concepts and Tactics

Function	Change Concept	Change Tactic
2 Care Management	**A. Assign and adjust risk status for each patient**	1. Use a consistent method to assign and adjust risk status for all empaneled patients in which the first step is an algorithm-based method and the second step adds information that the clinical team has about the patient.
		2. Monitor the risk stratification method and ensure accuracy and utility of risk status identification.
	B. Provide longitudinal care management to patients at high risk for adverse health outcome or harm	1. Use the risk stratification process to identify and target care management services to patients whom the team believes to be at high risk and amenable to longitudinal care management.
		2. Use on-site, non-physician, practice-based, or integrated shared care managers to proactively monitor and coordinate care for the highest-risk cohort of patients, with assistance from other practice staff, as needed.
		3. Develop a personalized care plan, integrating patient goals, values, and priorities and accessible to the patients and care team with patients at high risk for adverse health outcome or harm.

Function	Change Concept	Change Tactic
	C. Provide episodic care management, including management during transitions and acute care needs	1. Provide short-term (episodic) care management services to patients identified with acute or urgent needs (e.g., new diagnoses, medical crisis, decompensation in otherwise controlled chronic condition).
		2. Provide care transition planning and follow-up, including medication reconciliation, for patients with recent hospitalization.
		3. Provide necessary follow-up and medication reconciliation following emergency department (ED) discharge.
Care Management Requirements	See CPC+ Care Delivery Requirements in Appendix C	

FUNCTION 3: Comprehensiveness and Coordination

Comprehensiveness in the primary care setting refers to the capability to address as many of your patient population's medical, behavioral, and health-related social needs through your practice as is feasible. Coordination refers to the work of bridging the gaps between systems of care.

This work adds both breadth and depth to the delivery of primary care services; builds on the element of relationship that is at the heart of effective primary care; and is associated with overall lower utilization and costs, less fragmented care, and better health outcomes. It is essential to the care of persons with complex medical and social conditions.

CPC+ focuses on an important set of evidence-based strategies for better meeting the needs of patients with complex medical and social needs: 1) integration of behavioral health care into primary care, 2) intensive management of complex medication regimens, 3) identification of health-related social needs and referral to and coordination with community-based resources to address those needs, and 4) coordination in care and exchange of information with emergency departments, hospitals and specialists.

As a CPC+ practice, you will act as the hub of care for your patient population, and use data to identify population-specific needs and build capability, both within your practice and through referrals to address those needs.

Table 4: Comprehensiveness and Coordination Change Concepts and Tactics

Function	Change Concept	Change Tactic
3 Comprehensiveness and Coordination	**A. Integrate behavioral health clinicians into the primary care setting and workflow**	1. Incorporate appropriately trained and licensed staff into the primary care team to provide evidence-based behavioral health treatments and time-limited therapy.
		2. Use evidence-based, stepped care treatment algorithms that match treatment to patient preferences and consider response to prior treatments.
		3. Conduct regular case reviews with care team members for at-risk or unstable patients and those who are not responding to treatment.

Function	Change Concept	Change Tactic
	B. Implement behavioral health care management for patients with mental health conditions	1. Use care managers with behavioral health training to support management of patients receiving behavioral health treatment.
		2. Provide self-management support and treatment monitoring for patients with mental health conditions.
		3. Use a registry or health IT registry functionality to support active care management and outreach to patients in treatment.
		4. Use professional decision support, such as a psychiatric consult for patients with complex mental health needs.
		5. Ensure regular communications and coordinated workflows between primary care, behavioral health practitioners, and community services.
	C. Use evidence-based screening and case-finding strategies to identify individuals at risk and in need of behavioral health services	1. Routinely screen patients for depression, anxiety, dementia, and other mental health conditions.
		2. Integrate Screening, Brief Intervention, and Referral to Treatment (SBIRT), an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs into the practice setting.
	D. Manage medications to maximize efficiency, effectiveness, and safety	1. Conduct comprehensive medication reviews with patients that include action plans, individualized therapy goals, and planned follow-up, particularly for high-risk patients who: o Experience a transition of care o Receive longitudinal care management o Take high-risk medication
		2. Provide medication self-management support to improve adherence to prescribed medication.
		3. Work together with pharmacists and other health care professionals to promote clinically sound, cost-effective medication therapy and therapeutic outcomes (i.e., provide formulary management).
		4. Integrate a pharmacist into the care team to provide medication management services.

Function	Change Concept	Change Tactic
	E. Provide effective care coordination, navigation, and active referral management in the medical neighborhood	1. Ensure routine and timely follow-up to ED visits and hospitalizations.
		2. Work with targeted hospitals where the majority of your patients receive services to achieve timely of notification and transfer of information following hospital discharge and ED visit.
		3. Establish collaborative care agreements with frequently used or high-cost specialists and/or care agencies (e.g., home health agencies and skilled nursing facilities) that set expectations for documented flow of information and practitioner expectations between settings.
	F. Establish effective linkages with neighborhood/ community-based resources to support patient health goals and health-related social needs	1. Use and integrate a health-related social need screening tool/question(s) that will identify community and social service needs among the patient population, including a universal screening for all patients and a targeted screening for patients with complex needs.
		2. Develop and use a database of community and social services that is updated regularly.
		3. Coordinate referrals to community and social services and follow up with patients referred for services.
		4. Formalize coordination agreements to facilitate information sharing and linkages with community-based agencies and services.
		5. Track and measure success rates of linkages to community resources.
	G. Increase capability to manage medical conditions in the primary care setting that meet the needs of the practice population	1. Use payer data to identify common and complex health conditions seen in the population and develop strategies to address these needs in the practice.
		2. Expand collaboration with specialists to include strategies like co-location and co-management for common conditions.
Comprehensiveness and Coordination Requirements	See CPC+ Care Delivery Requirements in Appendix C	

FUNCTION 4: Patient and Caregiver Engagement

To achieve optimal care and health outcomes, patients and caregivers need to be engaged in the management of their own care and in the design and improvement of care delivery. Your practice can use a variety of strategies to gain insight into the patient and caregiver perspective on the organization and delivery of care, including Patient and Family Advisory Councils (PFACs), office-based surveys, and focus groups.

Your practice can support self-management of care through condition-specific training and tools, by integrating tools and strategies that apply across conditions into usual care, and by incorporating shared decision making strategies into care of selected conditions.

Values-based conversations about advance care planning can help your practice ensure your patients get the care they want when they are most vulnerable. Documentation of these conversations is especially valuable for frail and medically complex patients.

Table 5: Patient and Caregiver Engagement Change Concepts and Tactics

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

Function	Change Concept	Change Tactic
		5. Provide self-management materials at an appropriate literacy level and in an appropriate language.
		6. Use a shared agenda for the visit and provide health coaching between visits.
	C. Engage patients in shared-decision making	1. Engage patients in shared decision making about the risks and benefits of testing and treatments, where guidelines identify the decision as preference-sensitive.
		2. Use evidence-based decision aids to support shared decision making.
	D. Partner with patients and caregivers in advance care planning	1. Identify the population(s) with whom the clinician engages in advance care planning conversations.
		2. Schedule time during visits and prepare for planned conversations with patients who have serious illness and their caregivers about prognosis, values, goals, and care preferences.
		3. Document and communicate advance care discussions, including the patient's goals and preferences, in a manner accessible to the entire care team.
Patient and Caregiver Requirements	See CPC+ Care Delivery Requirements in Appendix C	

FUNCTION 5: Planned Care and Population Health

Central to the delivery of comprehensive primary care is organization of the practice into effective care teams that have the data they need to manage their panel of patients and that have time allocated to plan and implement strategies to improve care and outcomes. Using evidence-based protocols, registries, and the registry functionality of the EHR, reminders and outreach will help your practice deliver timely and appropriate preventive care, and consistent evidence-based management of chronic conditions for the entire population. Measurement of clinically relevant data at the level of the practice and the panel guides your practice's testing and implementation of strategies to improve care and outcomes.

Table 6: Planned Care and Population Health Change Concepts and Tactics

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

Function	Change Concept	Change Tactic
		3. Use panel support tools (e.g., registry functionality, reminders, phone calls, emails, post cards, text messaging, and community health workers where available) to identify, alert, and educate patients about regular services due and overdue, while also identifying patients for whom services otherwise due are inapplicable and why.
		4. Conduct regular care team meetings to review quality and cost data, and use the information to guide tactics to improve patient outcomes and value.
Planned Care and Population Health Requirements	See CPC+ Care Delivery Requirements in Appendix C	

DRIVER 2: Use of Enhanced, Accountable Payment

Table 7: Enhanced, Accountable Payment Change Concepts and Tactics

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

DRIVER 3: Continuous Improvement Driven by Data

Table 8: Continuous Improvement Change Concepts and Tactics

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

DRIVER 4: Optimal Use of Health IT

Table 9: Health IT Change Concepts and Tactics

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

DRIVER 5: Aligned Payment Reform

Table 10: Aligned Payment Reform Change Concepts and Tactics for CPC+ Payer Partners

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

Section II: Practice Reporting

Introduction

This section guides you through the 2018 CPC+ reporting your practice will complete. The information you collect and provide is incredibly valuable because it allows you to track your progress and direct your efforts to implement CPC+ at your practice. Further, your responses allow us to learn about your practice's capabilities and strategies for delivery of high-value, comprehensive primary care, as well as to measure the impact of your work on improving the cost and quality of care for your patients. This information will help us better understand the changes occurring in your practice, and improve learning activities to support your practice in providing comprehensive primary care. This section covers the two main types of practice reporting you will complete for CPC+: care delivery reporting and financial reporting.

This section includes questions, reporting frequency, definitions, and other notes to help you understand and complete your reporting. Your practice should use this section of the guide to prepare for reporting each quarter, and to proactively identify what information you will need to collect and track with others at your practice. We recommend reading the questions ahead of time and meeting with your team to discuss your practice's progress and to collect updates before reporting.

Some questions require input from different staff members in your practice, and you may choose to use data acquired in your electronic health record (EHR) or other health IT systems to inform your reporting. We recommend engaging your entire practice in reviewing and tracking your practice's responses to these questions, even if they are submitted by a single person working in your practice.

Please note that you are not required to use your EHR or health IT system to report, though many practices may choose to if their EHR or health IT system supports the appropriate data collection and reporting. You should always document what you report and be able to recreate the steps (e.g., screenshots or a record of how you generated the numbers) in the event of staffing changes at your practice. The documentation should also be retained to support your reported care delivery activities in the event of an audit.

Quarterly Submission Guide

You will complete your reporting in the CPC+ Practice Portal.[52] You can begin your reporting, save it, exit the CPC+ Practice Portal, and return later to continue and finish. The CPC+ Practice Portal will save your answers. Later in the year, you will be able to look back to previous quarter reports and print them for reference. We encourage you to start your reporting

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

as early in the reporting period as possible. The quarterly reporting timeline is illustrated in Figure 3. The submission period opens the last week of each quarter (though you will have to wait until the quarter ends to report some of the data). Directly after the submission period, you have the option to request a one-week extension (late submission period) to complete your reporting. Following approval of your request, you must complete your reporting in the week directly following the regular submission period for the quarter.

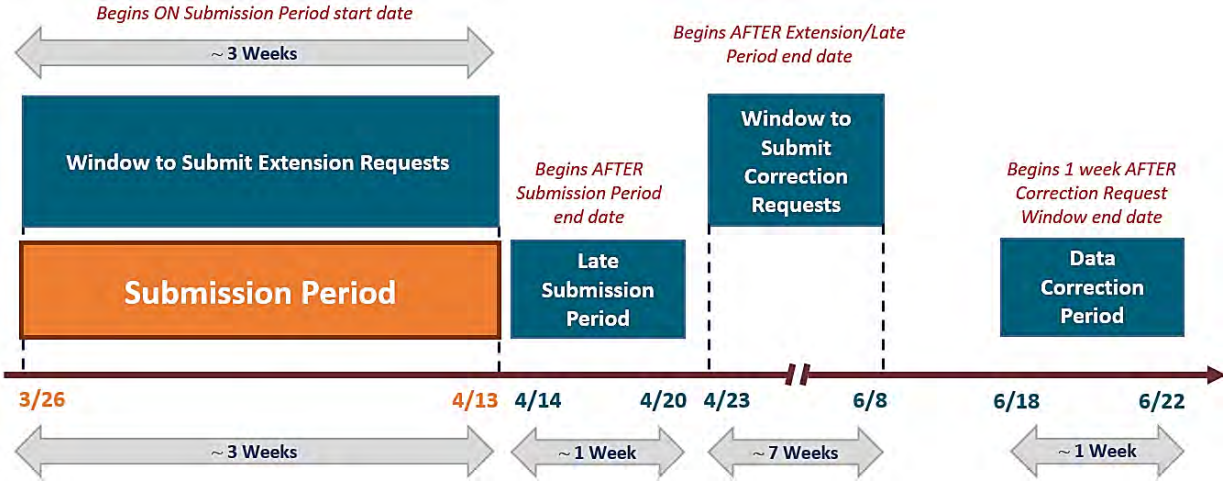

Figure 3: Quarterly Reporting Timeline

Table 11 shows the quarterly reporting periods for PY 2018. Care delivery reporting occurs quarterly, and financial reporting occurs only in Quarter 4 (Q4).

Table 11: CPC+ 2018 Reporting Submission Periods

	Q1	Q2	Q3	Q4*
Submission Period	3/26/18 to 4/13/18	6/25/18 to 7/13/18	9/24/18 to 10/12/18	12/31/18 to 1/25/19
Late Submission Period	4/14/18 to 4/20/18	7/14/18 to 7/20/18	10/13/18 to 10/19/18	1/26/19 to 2/1/19
Correction Request Window	4/23/18 to 6/8/18	7/23/18 to 9/7/18	10/22/18 to 12/7/18	2/4/19 to 3/8/19
Data Correction Period	6/18/18 to 6/22/18	9/17/18 to 9/21/18	12/17/18 to 12/28/18	3/18/19 to 3/22/19

*Financial reporting will occur during the Q4 submission period.

Extension and Correction Requests

Requests for an extension to submit your data during the late submission period must be submitted by the end of the regular submission period. Requests to correct submitted data will be available after the late submission period closes and must be submitted no later than one week prior to the beginning of the data correction period. All requests must be submitted via the CPC+ Practice Portal. To request approval for an extension or to correct data:

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

Approval to submit data during the late submission period and to correct previously submitted data during the correction period will be granted on a case-by-case basis. Your practice will be notified once the request has been approved or denied. If an extension has been approved, your data must be submitted during the late submission period. If you have not submitted your data by the end of the late submission period, your practice may be subject to remedial action by CMS.

You will not be able to use the data correction period to submit late data. The data correction period is only for corrections of previously submitted data. Please note that data corrections submitted during the correction period will not impact any learning or monitoring actions taken as a result of the data originally submitted but will be reflected in the subsequent monitoring period.

You can view the status of your data submission requests by clicking the **Request History** tab in the My Practice Info section of the CPC+ Practice Portal.

Table 12 cross-references each reporting domain with the quarter in which responses are required for PY 2018.

Table 12: PY 2018 Reporting by Quarter

Care Delivery Reporting Sections					
Function 1: Access and Continuity		**Q1**	**Q2**	**Q3**	**Q4**
1.1	Empanelment	●	(●)	(●)	(●)
1.2	24/7 Access	●		●	
1.3	Continuity of Care	●		●	
1.4	Enhanced Access and Communication	●	(●)	(●)	(●)
Function 2: Targeted Care Management		**Q1**	**Q2**	**Q3**	**Q4**
2.1	Risk Stratification	●		●	
2.2	Identifying Patients for Care Management	●	(●)	(●)	(●)
2.3	Care Management Staffing	●		●	
2.4	Care Plans		●		●
2.5	Coordinating with the Hospital and EDs Your Patients Use	●	(●)	(●)	(●)
2.5.1	Patient Follow-up	●	(●)	(●)	(●)

Function 3: Comprehensiveness and Coordination		Q1	Q2	Q3	Q4
3.1	Collaborative Care Agreements with Specialists	●	(●)	(●)	(●)
3.2	Identifying and Communicating with Hospitals and EDs Your Patients Use	●		●	
3.3	Comprehensive Medication Management		●		●
3.4	Behavioral Health Integration	●		●	
3.5	Linkages with Social Services	●		●	
3.5.1	Coordinating with Social Service Resources	●		●	
3.6	Comprehensiveness		●		●
Function 4: Patient and Caregiver Engagement		**Q1**	**Q2**	**Q3**	**Q4**
4.1	Engaging Patients and Caregivers in Your Practice	●	(●)	(●)	(●)
4.2	Self-Management Support for Selected Conditions	●	(●)	(●)	(●)
4.3	Advance Care Planning		●		●
Function 5: Planned Care and Population Health		**Q1**	**Q2**	**Q3**	**Q4**
5.1	Team-Based Care	●		●	
5.2	Use of Data to Plan Care		●		●
5.3	Continuous Quality Improvement		●		●
5.4	Culture of Improvement at Your Practice		●		●
General Practice Questions		**Q1**	**Q2**	**Q3**	**Q4**
General	CPCP% Selection (Track 2 only)			●	
General	CPC+ Payer Partners	●	(●)	(●)	(●)
General	Patient Demographics				●
General	CPC+ Program Questions	●	●	●	●
General	Reporting Point of Contact	●	●	●	●

When denoted by (•), prior responses for that reporting domain are pre-populated and only require updates.

Financial Reporting					
		Q1	**Q2**	**Q3**	**Q4**
Actuals	2018 Revenues				●
Actuals	2018 Expenditures				●
Forecast	2019 Revenues				●
Forecast	2019 Expenditures				●

Care Delivery Reporting Guide

Through care delivery reporting, you will tell us about activities at your practice that have occurred since the last time you reported on that element. We understand that, as part of CPC+, your practice is undergoing a large transformation, and that these types of changes can take time to implement. Please respond accurately to the best of your ability and focus on what has been implemented at your practice, rather than on things that are in planning or development, unless specifically prompted by the question. Your responses will help us to understand practice progress in the CPC+ care delivery functions, and inform our learning activities and care delivery requirements for future years.

Although we tailor our requirements and expectations to practices based on track and starting year, every practice must answer the same questions, except where noted. As a result, you may be asked questions that are not directly related to or feel more advanced than the care delivery requirements for your track or starting year. We do not expect all practices to be fully implementing every aspect of care delivery covered by the care delivery reporting questions. Please refer to the care delivery requirements for 2017 Starters and for 2018 Starters for clarification on what you are expected to implement for CPC+ in PY 2018.

Your responses to certain sections will carry over from quarter to quarter in the CPC+ Practice Portal. For these questions, you will only need to update your response if your practice's activities have changed since you last answered that question. We have noted that where applicable in the Notes section.

Function 1: Access and Continuity

1.1 Empanelment	**Notes**
Reporting Periods: Quarterly	
Do you primarily empanel patients by practitioner (i.e., each MD, DO, PA, or NP) or by care team (i.e., practitioner-led teams)? ○ Practitioner ○ Care Team	*A **care team** is a group of health professionals at your practice—Physicians, Registered Nurses, Physician Assistants, Clinical Pharmacists, and other health care professionals—with the training and skills needed to provide high-quality, coordinated care specific to patients' clinical needs and circumstances.* *Note: Prior responses to this question are shown, and only need to be updated.*

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

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

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

To find more information about empanelment, refer to the change concept Empanel all patients to a practitioner and/or care team (page 14) in Section I of this Guide.

What is your active patient lookback period?

- ○ Less than one year
- ○ 1-2 years
- ○ More than two years

1.2 24/7 Access

Reporting Periods: Quarters 1 and 3

Notes

Does a clinician or care team member **from your practice site** usually provide 24/7 coverage?

- ○ No, we do not provide 24/7 coverage
- ○ Yes
- ○ No, we have a centralized call-center for our health system (after-hours coverage for all practices in the system)
- ○ No, we have a formal coverage arrangement with another practice/ organization

Note: The members on your care team providing 24/7 coverage must include only licensed medical practitioners (i.e., MD/DO, NP, PA).

Note: If you answer "No, we do not provide 24/7 coverage," the next question is automatically skipped.

Is 24/7 coverage provided **with real-time access** to your practice's EHR?

- ○ Yes
- ○ No

Real time *refers to having access to current, up-to-date medical records in the EHR during off hours.*

1.3 Continuity of Care **Reporting Periods: Quarters 1 and 3**	**Notes**
Do you track continuity of care (in terms of how often patients see the practitioner or care team to which they are empaneled) for your patients? ○ Yes What system(s) do you primarily use to track continuity of care? (Select all that apply) ☐ EHR ☐ Electronic practice management systems (e.g., appointment scheduling system) ☐ Other, please specify: (textbox) ○ No	***Continuity of care*** *refers to an ongoing relationship between a patient and the practitioner(s) or care team to which they are empaneled for the delivery of care.* *Note: If you answer "Yes," the question asks for further details. If you answer "No," the next question is automatically skipped.* *To find more information about continuity of care, refer to the change concept Optimize continuity with the practitioner and/or care team (page 21) in Section I of this Guide.*
How does your practice measure continuity of care? (Select all that apply) ○ We use patient-centric measures ○ We use practitioner-centric measures ○ Other, please specify: (textbox)	*The* ***patient-centric measure*** *is (the total number of visits to a practitioner by all patients empaneled to that clinician) divided by (the total number of visits by that patient panel to any primary care practitioner).* *The* ***practitioner-centric measure*** *is (the total number of visits to a clinician by all patients empaneled to that clinician) divided by (the total number of visits conducted by that clinician).* *To find more information about patient- and practitioner-centric measures, refer to the change concept Optimize continuity with the practitioner and/or care team (page 21) in Section I of this Guide.*

1.4 Enhanced Access and Communication	Notes
Reporting Periods: Quarterly	

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

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

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

In the last quarter, in which of the following ways did your practice provide alternative approaches to care other than traditional office-based visits? (Select all that apply)

☐ We did not provide alternative approaches to care

Services	How many of your patients who could benefit from this type of care received it?	For each of the alternative care approaches you selected, who primarily provided this care? (Select all that apply)
☐ Visits in alternative locations (e.g., nursing facilities, hospitals, senior centers)	○ None ○ Some ○ Most ○ All	☐ MD/DO ☐ NP/PA ☐ Other care team members, please specify: (textbox)
☐ Home-based care (e.g., primary care home visits)	○ None ○ Some ○ Most ○ All	☐ MD/DO ☐ NP/PA ☐ Other care team members, please specify: (textbox)
☐ Medical group visits (e.g., shared medical appointments)	○ None ○ Some ○ Most ○ All	☐ MD/DO ☐ NP/PA ☐ Other care team members, please specify: (textbox)
☐ Video-based conferencing (i.e., telehealth or tele-medicine)	○ None ○ Some ○ Most ○ All	☐ MD/DO ☐ NP/PA ☐ Other care team members, please specify: (textbox)
☐ Medical visit over an electronic exchange (i.e., phone or, e-visit, portal).	○ None ○ Some ○ Most ○ All	☐ MD/DO ☐ NP/PA ☐ Other care team members, please specify: (textbox)
☐ Other, please specify: (textbox)	○ None ○ Some ○ Most ○ All	☐ MD/DO ☐ NP/PA ☐ Other care team members, please specify: (textbox)

*Requirements differ by starting year and track. **Track 2** practices are expected to provide at least one alternative for care outside of traditional office visits.*

To find more information about alternative care approaches, refer to the change concept Ensure timely access to care (page 16) in Section I of this Guide.

This set of questions refer to medical care alternative to traditional face-to-face office-based visits for 2017 starters. Alternative care does not include extended hours, use of a patient portal, or secure messaging for 2017 starters.

Note: If you answer, "We did not provide alternative approaches to care," the questions in the table on alternative visits are automatically skipped.

Note: If you select an option under the "Service" column, the entire row will be enabled.

Note: The following estimates should be used to guide your response: None (0%), Some (Up to 50% of all patients), Most (50-95%), All (95-100%). Please give us your best guess, as you are not required to give us exact percentages.

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

(Optional) In addition to the alternative care described in the table above, in what ways has your practice used Comprehensive Primary Care Payments (CPCPs) to increase access outside of the traditional office visit? (textbox)	*This question is for **Track 2** CPC+ practices only. The CPCP is intended to support flexible delivery of care beyond traditional office visits.* *Note: Prior responses to this question are shown, and only need to be updated.* *To find more information about the CPCP, refer to the change concept Use forecasting and accounting processes effectively to transform care and build capability to deliver comprehensive primary care (page 83) in Section I of this Guide.*

Function 2: Targeted Care Management

2.1 Risk Stratification	Notes
Reporting Periods: Quarters 1 and 3	
Do you risk stratify your empaneled patients? ○ Yes ○ No, we do not risk stratify our patients	*All practices are expected to implement risk stratification for all empaneled patients. Specific requirements differ by starting year and track.*
Do you use a two-step process for risk stratifying your empaneled patients? ○ Yes ○ No	*For Track 2 practices, CPC+ defines the two-step risk stratification process as:* *• Step 1 – Base risk stratification on defined diagnoses, claims, or another algorithm (i.e., not care team intuition).* *• Step 2 – Add the care team's perception of risk (care team/ clinical intuition) to adjust the risk stratification of patients, on an as-needed basis.* *Note: If you select "No, we do not risk stratify our patients," the remaining questions for this section are automatically skipped.* *To find more information about risk stratification, refer to the change concept Assign and adjust risk status for each patient (page 25) in Section I of this Guide.*
What factors are included in your **data-driven algorithm** for risk stratifying your patients? (Select all that apply) ☐ We do not use a data-driven algorithm as part of our risk stratification ☐ Claims variables ☐ Clinical variables from the EHR ☐ Computed risk scores (e.g., CMS-HCC scores or risk scores from other payers) ☐ Other, please specify: (textbox)	*Use of **clinical perception or intuition** is not considered a factor in data-driven algorithms.* *Note: If you select "We do not use a data-driven algorithm as a part of our risk stratification," you will be unable to select the other options for this question.*

What factors do you consider when using **care team/clinical intuition** to stratify your patients? Do not include factors included in your data-driven algorithm. (Select all that apply) ☐ We do not use the care team's perception as part of our risk stratification ☐ Social needs ☐ Behavioral health needs ☐ Clinical factors ☐ Other, please specify: (textbox)	***Clinical intuition/care team perception*** *is a practitioner's and/or care team's knowledge of a patient and a global assessment of the patient's risk, which may include clinical, social, and behavioral risk.* *Note: Social needs includes factors such as lack of transportation, changes in caregiver support, food insecurity, and/or housing instability.* *Note: If you select "We do not use the care team's perception as part of our risk stratification," you will be unable to select the other options for this question.* *To find more information about risk stratification and clinical intuition, refer to the change concept Assign and adjust risk status for each patient (page 25) in Section I of this Guide.*
What prompts reassessment of a patient's risk stratification assignment? ○ We do not reassess the risk stratification of our patients ○ Only as needed, or we do not have a protocol in place ○ Pre-specified clinical events (e.g., new diagnosis, hospitalization) ○ Automatically updated when new information is in the health IT or EHR platform ○ Schedule-driven protocol ☐ At each patient visit ☐ Multiple times a year ☐ Annually ☐ Other, please specify: (textbox) ○ Other, please specify: (textbox)	*The intent of this question is to understand the* ***primary*** *reason for the reassessment of your patients' risk stratification assignments. Your practice may reassess risk for multiple reasons as part of your process.* *Note: If you select "We do not reassess the risk status of our patients," you will be unable to select the other options for this question.* *Note: If you select "Schedule-driven protocol," you will be prompted to indicate the frequency.*
Is risk stratification integrated within your EHR or health IT system? ○ Yes ○ No	***Track 2*** *practices must integrate the capability to risk stratify the practice site patient population and identify and flag patients with complex needs into the EHR or health IT system.*

2.2 Identifying Patients for Care Management

Reporting Periods: Quarterly

In the table below, please tell us how your patient population is risk stratified and targeted for care management, using your practice's chosen risk stratification method. Report your patient counts based on a convenient day or moment, as close as possible to the last day of the month.

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

Notes

Longitudinal care management *is intensive, ongoing, relationship-based care for patients at highest risk for adverse, preventable outcomes. For this table:*

- ***Level of Risk:*** *When reporting, the CPC+ Practice Portal will allow you to generate a row for each risk tier in your risk stratification method. Label the rows using the terminology your practice uses to define risk. Place risk tiers in descending order, with the highest risk tier at the top and the lowest at the bottom. Your risk tiers will carry over from the risk tiers you reported in the prior quarter, but you will be able to edit them if your practice has changed its risk stratification approach.*

  If your risk stratification method includes a tier for low or no risk, please make sure to include that row here, separate from the "Not assigned' tier. The "Not assigned" tier should only include patients for whom you have not created a risk score at all.

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

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

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

	• ***Percent of patients under longitudinal care management:*** *This column will auto-calculate the percentage of active patients who are under care management.* • ***Target patients for care management:*** *Mark the tier(s) used to target patients for longitudinal care management. For example, your practice may target patients for care management based on the highest risk tier.*
<table><tr><th>% of Patients</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr><tr><td>% of patients under care management out of total empaneled</td><td></td><td></td><td></td><td></td></tr><tr><td>% of patients risk stratified out of total empaneled</td><td></td><td></td><td></td><td></td></tr></table>	*Note: Table cells with a diagonal pattern indicate content that is auto-calculated. These data are intended to help you track rates over time. For example, in Quarter 2, your Quarter 1 rates are auto-calculated and included in this column.*
Indicate how you identify patients for episodic care management. This refers to short-term, goal-directed care management for **patients who are not already in longitudinal care management** as a result of their risk status. (Select all that apply) ☐ We do not identify patients for episodic care management ☐ Practitioner or care team referral ☐ Hospital admission or discharge ☐ ED visit ☐ Skilled Nursing Facility (SNF) admission or discharge ☐ New health condition (e.g., cancer diagnosis, accident, chronic condition) ☐ New clinical instability in a chronic condition, including change in medications ☐ Life event (e.g., death of spouse, financial loss) ☐ Initiation or stabilization on a high-risk medication (e.g., anticoagulants) ☐ Other, please specify: (textbox)	***Episodic care management*** *is short-term, goal-directed care for patients who your practice has not already targeted for longitudinal care management.* *Note: If you select "We do not identify patients for episodic care management," you will be unable to select the other options for this question.* *Note: Prior responses to this question are shown, and only need to be updated.* *To find more information about episodic care management, refer to the change concept Provide episodic care management, including management across transitions and acute care needs (page 33) in Section I of this Guide.*

2.3 Care Management Staffing

Reporting Periods: Quarters 1 and 3

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

Activities	None	Practitioner (i.e., MD, DO, NP, PA)	Care manager/ clinical staff (e.g., RN, LPN, social worker)	Other clinical staff (e.g., MA/CMA, CNA)	Non-clinical staff (e.g., admin, front desk)	Other, please specify: (textbox)
Developing and monitoring care plans	○	○	○	○	○	○
Assessing and reassessing patient risk status	○	○	○	○	○	○
Providing patient education and self-management support	○	○	○	○	○	○
Routine medication reconciliation at scheduled visits	○	○	○	○	○	○
Medication reconciliation during transitions of care (hospital, ED discharges)	○	○	○	○	○	○
Management of care transitions (hospital, ED discharges)	○	○	○	○	○	○
Coordinating and communicating with specialty care	○	○	○	○	○	○
Navigating patients to community and social services	○	○	○	○	○	○

Notes

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

For example, if a care team member at your practice does the bulk of routine medication reconciliation during scheduled visits to patients, but an NP/PA sometimes fills in, the care team member is the person primarily responsible for this activity.

2.4 Care Plans **Reporting Periods: Quarters 2 and 4**	**Notes**
Among patients under longitudinal care management, how many have a care plan? ○ None ○ Some ○ Most ○ All	*Requirements differ by starting year and track.* *A **care plan** is a mutually agreed upon and documented plan of care based on the patient's goals, needs, and self-management activities and is accessible to all team members providing care for the patient.* *For purposes of CPC+, "care plan" and "plan of care" are used synonymously.* *Note: The following estimates should be used to guide your response: None (0%), Some (Up to 50% of all patients), Most (50-95%), All (95-100%). Please give us your best guess, as you are not required to give us exact estimates.* *Note: If you answer "None," the remaining questions for this section are automatically skipped and you will move on to Section 2.5.*
Do you document and store care plans? ○ No ○ Yes, care plans are **integrated** with the EHR or other health IT ○ Yes, care plans are documented and stored, but are **not integrated** with the EHR or other health IT	***Track 2** practices must integrate the capability to document and store patient-focused care plans to guide care management within the EHR or other health IT.* *Note: Examples of integrated care plans into the EHR include modules and templates.*
Who has real-time/point-of-care access to a patient's care plan? (Select all that apply) ☐ Members of the care team within the practice ☐ Clinicians outside of the practice (i.e., other specialists who care for the patient) ☐ Community and/or social service agencies and practitioners ☐ Patient and his/her caregiver(s) ☐ Other, please specify: (textbox)	***Real time** refers to having access to current, up-to-date medical records in the EHR.*

2.5 Identifying Hospitals and EDs Your Patients Use

Reporting Periods: Quarterly

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

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

Notes

Target hospital(s) and EDs *are those hospital/EDs used by the majority of your patients with whom you are working with to improve follow-up and timeliness of data transfer. For example, if you are in an area with multiple hospitals, list up to three hospitals that are used most frequently by your patients.*

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

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

Note: Only three hospitals/EDs can be entered for this question. If your practice entered more than three hospitals/EDs in 2017, prior responses for only the first three hospitals/EDs listed will be carried over from Q4 2017 to Q1 2018.

2.5.1 Patient Follow-up

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

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

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

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

Note: This table asks you to report on total numbers for the reporting quarter. Please refer to the CPC+ 2018 Reporting Submission Periods table for quarterly reporting date ranges.

- ***Name of ED:*** *A row is generated for each ED you listed in the previous question.*
- ***Number of patient discharges:*** *Indicate the number during the reporting quarter.*
- ***Number of patient discharges with follow-up:*** *Indicate the number during the reporting quarter.*
- ***Percent of discharges with follow-up:*** *This column will auto-calculate.*
- ***We do not track discharges:*** *If you select this, you will not be able to enter discharge or follow-up numbers for those ED(s).*

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

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

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

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

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

Note: In the table, provide the counts of your empaneled patient discharge from the hospital during this quarter and those who received follow-up contact to their home or a skilled nursing facility (SNF) within 72 hours or 2 business days after visiting the hospital. Note that an individual patient may have more than one discharge, and we are counting the number of discharges, not patients. Please include observation stays.

Note: This table asks you to report on total numbers for the reporting quarter. Please refer to the CPC+ 2018 Reporting Submission Periods table for quarterly reporting date ranges.

- ***Name of hospital:** A row is generated for each hospital you listed in the previous question.*
- ***Number of patient discharges:** Indicate the number during the reporting quarter.*
- ***Number of patient discharges with follow-up:** Indicate the number during the reporting quarter.*
- ***Percent of discharges with follow-up:** This column will auto-calculate.*
- ***We do not track discharges:** If you select this, you will not be able to enter discharge or follow-up numbers for those hospitals).*

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

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

Function 3: Comprehensiveness and Coordination

3.1 Collaborative Care Agreements with Specialists	Notes
Reporting Periods: Quarterly	
Note: For auditing purposes, you are required to retain a copy of your signed collaborative care agreements and care compacts for 10 years per CMS policy.	

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

☐ We have not established care compacts or collaborative care agreements.

Specialists

☐ Allergy/Infectious disease
☐ Cardiology
☐ Dermatology
☐ Emergency medicine
☐ Endocrinology
☐ ENT/Otolaryngology
☐ Gastroenterology
☐ Hospitalist care
☐ Nephrology
☐ Neurology
☐ Obstetrics/Gynecology
☐ Oncology/Hematology
☐ Ophthalmology
☐ Optometry
☐ Orthopedic surgery
☐ Palliative care
☐ Pain management
☐ Podiatry
☐ Psychiatry/Psychology
☐ Pulmonology
☐ Radiology
☐ Rheumatology
☐ Surgery
☐ Urology
☐ Other, please specify: (textbox)

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

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

Note: If you select "We have not established care compacts or collaborative care agreements," you will be unable to select the other options for this question and the remaining questions for this section are automatically skipped.

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

To find more information about care compacts and collaborative care agreements, refer to the change concept Provide effective care coordination, navigation, and active referral management in the medical neighborhood (page 49) in Section I of this Guide.

3.2 Identifying and Communicating with Hospitals and EDs Your Patients Use

Reporting Periods: Quarters 1 and 3

Notes

These questions assess the extent to which your practice communicates and coordinates with your top three hospitals and the emergency departments (EDs) you identified in Section 2.5.

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

Hospital/ ED	How promptly do you have access to ADT information about your patients seen at this hospital/ED?	What primary communication vehicle(s) do you use to obtain ADT information? (Select all that apply)
Name of hospital/ ED auto-populated (textbox)	○ We do not have access to ADT information from this hospital/ED ○ At time of event ○ Daily ○ Within 1 week ○ Within 2 weeks ○ Over 2 weeks	☐ Phone ☐ Fax/eFax ☐ Secure email or direct messages ☐ Health Information Exchange (HIE) ☐ Access to hospital/ED EHR or shared hospital EHR ☐ Third-party software or tool (e.g., ACO or system report, Premanage, Patient Ping) ☐ Other, please specify: (textbox)

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

Note: If you select "We do not have access to ADT information from this hospital/ED," you will be unable to select any other options for that hospital/ED or answer the follow-up question "What primary communication vehicle(s) do you use to obtain ADT information?"

To find more information about communication of ADT information between practices/ hospitals/EDs, refer to the change concept "Provide effective care coordination, navigation, and active referral management in the medical neighborhood (page 49) in Section I of this Guide.

3.3 Comprehensive Medication Management

Reporting Periods: Quarters 2 and 4

Notes

***Comprehensive medication management (CMM)** is a collaboration between the primary care team and a CMM specialist (often a pharmacist) working with patients and caregivers to deliver high-quality medication management services. CMM differs from routine medication reconciliation done at visits, or during transitions of care. Medication reconciliation is a starting point for safer, more effective medication management.*

*Requirements differ between start year and track. Please refer to the care delivery requirements for **2017 Starters** and for **2018 Starters** for clarification.*

Which of the following steps has your practice achieved to implement comprehensive medication management? (Select all that apply)

- ☐ We have not taken any of these steps yet
- ☐ Established a plan for identifying patients with CMM needs
- ☐ Identified and/or hired personnel for CMM
- ☐ Trained staff as necessary
- ☐ Developed workflows and processes

In the last two quarters, has your practice provided comprehensive medication management to patients? ○ No, we are not implementing comprehensive medication management ○ No, we are in the process of developing a plan for comprehensive medication management ○ No, we have established a plan for comprehensive medication management, but have not yet implemented it ○ Yes, we provided comprehensive medication management support	*Note: If you select "No, we are not implementing comprehensive medication management," you will be unable to select the other options for this question and the remaining questions for this section are automatically skipped.* *For more information about CMM, refer to the change concept Manage medications to maximize efficiency, effectiveness, and safety (page 47) in Section I of this Guide.*
Who primarily provides comprehensive medication management for your patients? ○ Pharmacist ○ Primary care practitioners at our practice (MD/DO, NP/PA) ○ Other, please specify: (textbox)	*Note: If you selected **any** of the "No" options for the second question in this section, this question is automatically skipped.*
How does your practice deliver comprehensive medication management? ○ Coordination with an **external** pharmacist, program, or service ○ Co-management with a pharmacist, program, or service **located at our practice** ○ **Primary care practitioners** from our practice primarily deliver comprehensive medication management	*Note: If you selected **any** of the "No" options for the second question in this section, this question is automatically skipped.*
How do you identify patients for comprehensive medication management? (Select all that apply) ☐ Recent discharge from the hospital ☐ Patients who are receiving longitudinal care management ☐ Recent visit to ED ☐ Active medication issues (e.g., adverse reactions, adherence, not reaching intended treatment outcomes) ☐ Potential therapy issues (e.g., high risk medications, poly-pharmacy, multi-therapy drug interactions, high cost medications) ☐ Referred by practitioner or care team ☐ Other, please specify: (textbox)	*Note: If you selected **any** of the "No" options for the second question in this section, this question is automatically skipped.*

3.4 Behavioral Health Integration	Notes
Reporting Periods: Quarters 1 and 3	
What is your practice's primary strategy for addressing behavioral health needs? If you are planning to integrate one of the behavioral health models listed below, please select that option. ○ We are not addressing behavioral health needs at our practice ○ Behavioral health integration with **Care Management for Mental Illness** (Option 1) ○ Behavioral health integration with the **Primary Care Behaviorist model** (Option 2) ○ Referrals or care compacts/collaborative agreements for external behavioral health specialists ○ Other, please specify: (textbox)	*Requirements differ between start year and track. Please refer to the care delivery requirements for **2017 Starters** and for **2018 Starters** for clarification.* *Note: If you select "We are not addressing behavioral health needs at our practice," you will be unable to select the other options for this question and the remaining questions for this section area automatically skipped.* *Note: The option "Referrals or care compacts/collaborative agreements for external behavioral health specialists" is not a behavioral health integration strategy, but rather an approach to managing patients' behavioral health needs.* *Find more information about behavioral health integration (BHI), Care Management for Patients with Mental Health, and the Primary Care Behaviorist model, refer to the change concepts Integrate behavioral health clinicians into the primary care setting and workflow (page 39) and Implement behavioral health care management for patients with mental health conditions (page 43) in Section I of this Guide.*

What mental health conditions are you targeting with your behavioral health strategy? (Select all that apply) ☐ We do not target specific mental health conditions ☐ Anxiety disorders ☐ Alzheimer's disease and related dementias ☐ Depressive disorders ☐ Chronic pain ☐ Complex/chronic disease and comorbidities (e.g., major depressive disorder, poorly controlled diabetes) ☐ High-risk behaviors (e.g., tobacco use, obesity, medication adherence) ☐ Insomnia ☐ Substance use disorders ☐ Other, please specify: (textbox)	*Note: If you select "We do not target specific mental health conditions," you will be unable to select the other options for this question.*
What types of targeted tactics for your patients are available at your practice? (Select all that apply) ☐ We do not use any targeted tactics for behavioral health ☐ Screening for behavioral health conditions as standard practice ☐ SBIRT (e.g., alcohol misuse) ☐ Evidence-based psychotherapy (e.g., CBT, PST) ☐ Self-management support for behavioral health conditions ☐ Counseling for behavior change (e.g., smoking cessation, weight loss) ☐ Other, please specify: (textbox)	***SBIRT** – Screening, Brief Intervention, Referral to Treatment* ***CBT** – Cognitive behavioral therapy* ***PST** – Problem-solving therapy* *Evidence-based screening tools may also include:* • *AUDIT-C and DAST* • *Mini Mental Status Examination* • *PHQ-2 or PHQ-9* • *GAD-7* *Note: If you select "We do not use any targeted tactics for behavioral health," you will be unable to select other options for this question.* *Find more information about additional targeted tactics, refer to the change concepts Integrate behavioral health clinicians into the primary care setting and workflow (page 39) and Implement behavioral health care management for patients with mental health conditions (page 43) in Section I of this Guide.*

If you selected care management for mental illness (Option 1) for the question "*What is your practice's primary strategy for addressing behavioral health needs?,*" you will answer the following set of questions.	
Which of the following steps has your practice achieved to integrate behavioral health? (Select all that apply) ☐ We have not taken any of these steps yet ☐ Established a plan for identifying patients with behavioral health needs ☐ Identified and/or hired personnel ☐ Trained staff as necessary ☐ Developed workflows and processes	*Note: If you select "We have not taken any of these steps yet," you will be unable to select the other options for this question.*
Who primarily provides care management for mental illness? ○ We do not have a care manager for mental illness at our practice ○ Licensed behavioral health clinician (e.g., LCSW, psychologist) ○ Care manager (e.g., RN, LPN) ○ Other, please specify: (textbox)	*Note: If you select "We do not have a care manager for mental illness at our practice," you will be unable to select the other options for this question.*
In the last two quarters, of your patients with identified behavioral health needs, estimate how many received behavioral health care management at your practice: ○ None ○ Some ○ Most ○ All	*Note: The following estimates should be used to guide your response: None (0%), Some (Up to 50% of all patients), Most (50-95%), All (95-100%). Please give us your best guess, you are not required to give us exact estimates.*
If you selected the Primary Care Behaviorist model for the question "*What is your practice's primary strategy for addressing behavioral health needs?*" you will see the following set of questions.	
Which of the following steps has your practice achieved to integrate behavioral health? (Select all that apply) ☐ We have not taken any of these steps yet ☐ Established a plan for identifying patients with behavioral health needs ☐ Identified and/or hired personnel ☐ Trained staff as necessary ☐ Developed workflows and processes	*Note: If you select "We have not taken any of these steps yet," you will be unable to select the other options for this question.*
What type of practitioner(s) act as primary care behaviorist(s) at your practice? (Select all that apply) ☐ We do not have a primary care behaviorist ☐ Psychologist ☐ Social worker (LCSW) ☐ Psychiatric NP/PA ☐ Other, please specify: (textbox)	*Note: If you select "We do not have a primary care behaviorist," you will be unable to select the other options for this question.*

In the last two quarters, of your patients with identified behavioral health needs, estimate how many were seen by a primary care behaviorist at your practice: ○ None ○ Some ○ Most ○ All	*Note: The following estimates should be used to guide your response: None (0%), Some (Up to 50% of all patients), Most (50-95%), All (95-100%). Please give us your best guess, you are not required to give us exact estimates.*
3.5 Linkages with Social Services **Reporting Periods: Quarters 1 and 3**	**Notes**
*Requirements differ between start year and track. Please refer to the care delivery requirements for **2017 Starters** and for **2018 Starters** for clarification.*	
Do you routinely screen your patients for unmet social needs? ○ We **do not screen** patients for unmet social needs ○ We screen **a targeted subpopulation of patients** for unmet social needs ○ We universally screen **all patients** for unmet social needs	*Note: If you select "We do not screen patients for unmet social needs," the next two questions are automatically skipped.*
What type of screening tool(s) do you use or adopt to capture unmet social needs in your patient population? (Select all that apply) ☐ We do not use any screening tools ☐ Standardized screening tool (e.g., screening tools published by HealthLeads, IOM/NAM, Accountable Health Communities [AHC]) ☐ Tool developed by practice or system ☐ Other, please specify: (textbox)	*Note: The question does not pertain to when the screening occurs (e.g., during AWV) or where the screening tool is located (e.g., EHR).* *Note: This section is specific to addressing social needs, and not behavioral or mental health needs. Behavioral and mental health needs are covered in 3.4 Behavioral Health Integration.* *Note: If you select "We do not use any screening tools," you will be unable to select the other options for this question.* *To find more information about assessing your patients for social needs, refer to the change concept Establish effective linkages with neighborhood/community-based resources to support patient health goals and health-related social needs (page 53) in Section I of this Guide.*

Are screening tools or questions integrated with your EHR or health IT system? ○ Yes ○ No	***Track 2** practices must integrate the capability to systematically assess patients' psychosocial needs and inventory resources and supports to meet those needs into the EHR.* *Note: If you selected "We do not use any screening tools" in the previous question, this question is automatically skipped.*
What are the social needs your practice has prioritized to address in your patient population? (Select all that apply) ☐ We have not prioritized any social needs to address in our patient population ☐ **Food insecurity:** Limited or uncertain access to adequate and nutritious food ☐ **Housing instability**: Homelessness, unsafe housing quality, inability to pay mortgage/rent, eviction ☐ **Utility needs:** Difficulty paying utility bills, shut off notices, disconnected phone ☐ **Financial resource strain:** Inability to pay for basics such as food, medical care, insurance, and medication costs ☐ **Transportation:** Difficulty accessing/affording transportation (i.e., medical or public) ☐ **Employment:** Under-employment/unemployment ☐ **Social isolation**: Lack of family and/or friend networks, minimal community contacts, absence of social engagement ☐ **Safety:** Intimate partner violence, elder abuse, community violence ☐ **Other**, please specify: (textbox)	*Note: This section is specific to addressing social needs, and not behavioral or mental health needs. Behavioral and mental health needs are covered in 3.4, Behavioral Health Integration.* *Note: If you select "We have not prioritized any social needs to address in our patient population," you will be unable to select the other options for this question.*

3.5.1 Coordinating with Social Service Resources	
How frequently is the inventory of social service resources your practice uses updated? ○ We do not maintain or have access to an inventory of these resources ○ Ad hoc basis only ○ At least monthly ○ Every 2-6 months ○ Every 6-12 months ○ Less than annually	*In CPC+, the **inventory** is a catalog or a listing of social service resources available in your community that your practice uses to meet your patients' social needs. Your practice may create your own or use an existing inventory.* *Note: If you select "We do not maintain or have access to an inventory of these resources," you will be unable to select the other options.* *To find more information about social service inventories, refer to Establish effective linkages with neighborhood/community-based resources to support patient health goals and health-related social needs (page 53) in Section I of this Guide.*
Is the inventory of social service resources integrated with your EHR? ○ Yes ○ No	***Track 2** practices must integrate the capability to systematically assess patients' psychosocial needs and inventory resources and supports to meet those needs into the EHR.* *Note: If you select "We do not maintain or have access to an inventory of these resources," in the previous question, this question is automatically skipped.*
Identify the social service resources and supports with whom you have established relationships to address the prioritized areas you selected above. (Select all that apply) ☐ We have not established relationships with social service resources and supports ☐ Financial (e.g., TANF, SSDI/SSI, cash assistance) ☐ Nutrition and Food (e.g., SNAP/WIC, food pantries, Meals on Wheels) ☐ Health-related services (e.g., insurance, prescription assistance, home health, durable medical equipment) ☐ Housing (e.g., shelter, public housing, transitional support) ☐ Transportation (e.g., medical transport, public transit) ☐ Utilities (e.g., energy assistance/subsidies [LIHEAP], telephone) ☐ Other, please specify: (textbox)	*The intent of this question is to clarify what relationships have been established to meet the social needs prioritized by your practice for your patient population.* *Note: If you select "We have not established relationships with social service resources and supports," you will be unable to select the other options for this question.*

3.6 Comprehensiveness	Notes
Reporting Periods: Quarters 2 and 4	

Requirements differ between start year and track. Please refer to the care delivery requirements for 2017 Starters and for 2018 Starters for clarification.

As part of your practice's work to increase comprehensiveness, what is/are the complex need(s) your practice is developing capabilities to address? (Select all that apply)

☐ We are not developing capabilities to increase comprehensiveness

Complex Needs	What services or capabilities are you developing to meet the needs of patients with this specific complex need?
☐ End of life or palliative care	(textbox)
☐ Chronic pain	(textbox)
☐ Substance use disorders	(textbox)
☐ Co-existing chronic conditions	(textbox)
☐ High-acuity chronic conditions, please specify: (textbox)	(textbox)
☐ Alzheimer's Disease and related dementias	(textbox)
☐ Frailty	(textbox)
☐ Other, please specify: (textbox)	(textbox)

***Comprehensiveness** in the primary care setting refers to the capability to address as many of your patient population's medical, behavioral, and health-related social needs through your practice as is feasible.*

***High-acuity chronic conditions** refer to advanced diseases, such as advanced diabetes, advanced chronic obstructive pulmonary disease (COPD), advanced cancer, and higher stage chronic kidney disease (CKD). Therefore, complex needs for patients with chronic conditions and high-acuity chronic conditions may differ.*

Note: If you select "We are not developing capabilities to increase comprehensiveness," you will be unable to select the other options for this question.

To find more information about medical, behavioral, and health-related social needs, refer to the change concept Increase capability to manage medical conditions in the primary care setting that meet the needs of the practice population (page 55) in Section I of this Guide.

Function 4: Patient and Caregiver Engagement

<table>
<tr><th colspan="7">4.1 Engaging Patients and Caregivers in Your Practice</th><th rowspan="2">Notes</th></tr>
<tr><th colspan="7">Reporting Periods: Quarterly</th></tr>
<tr><td colspan="7">Tell us how frequently your practice engages patients and caregivers in…

<table>
<tr><th>Activities</th><th>Never</th><th>Rarely</th><th>Some-times</th><th>Often</th><th>Always</th></tr>
<tr><td>… developing agendas for Patient and Family Advisory Council (PFAC) meetings.</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>… establishing improvement projects.</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>… communicating results of improvement projects.</td><td></td><td></td><td></td><td></td><td></td></tr>
</table></td><td>The intent of this question is to better understand how your practice is engaging patients and caregivers in quality improvement processes and setting practice transformation priorities.

<u>Note:</u> Prior responses to this question are shown, and only need to be updated.</td></tr>
<tr><td colspan="7">Which of the following steps has your practice achieved to implement and integrate the PFAC? (Select all that apply)
☐ We have not taken any of these steps
☐ Identified staff participants
☐ Recruited patient participants
☐ Defined mission and vision of the PFAC
☐ Determined structure of the PFAC (e.g., number of patients or family advisors, frequency of meetings, term lengths, and other meeting logistics)
☐ Incorporated PFAC recommendations into practice
☐ Communicated PFAC recommendations to patients and staff
☐ Developed a sustainability plan for the PFAC</td><td>The steps listed here for PFAC integration are not necessarily sequential.

<u>Note:</u> If you select “We have not taken any of these steps,” you will be unable to select the other options for this question and the remaining questions for this section are automatically skipped.

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

To find more information about establishing a PFAC representative of your patient demographic, refer to the change concept <u>Engage patients and caregivers to guide improvement in the system of care</u> (page 58) in Section I of this Guide.</td></tr>
<tr><td colspan="7">Identify the number of meetings held by your practice’s PFAC in the last quarter: (textbox)</td><td>Requirements differ between start year and track. Please refer to the care delivery requirements for <u>2017 Starters</u> and for <u>2018 Starters</u> for clarification.

<u>Note:</u> For audit purposes, you are required to retain all meeting minutes for 10 years per CMS policy.</td></tr>
</table>

Who typically meets with or is a part of your PFAC?

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

The intent of this question is to better understand who is participating in your PFAC. Please estimate the average makeup of your PFAC. Exact numbers are not necessary.

Note: Include management as "Non-clinical staff" and Pharm.D., behavioral health staff, and social workers, etc. as "Clinical staff."

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

Rate how well your PFAC reflects your practice's overall patient population (i.e., based on factors like age, gender, race, socioeconomic status, language, or medical conditions)

- ○ Not applicable, or the PFAC is still in development
- ○ Not at all representative
- ○ Slightly representative
- ○ Moderately representative
- ○ Very representative
- ○ Completely representative

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

To find more information about establishing a PFAC representative of your patient demographic, refer to the change concept Engage patients and caregivers to guide improvement in the system of care (page 58) in Section I of this Guide.

4.2 Self-Management Support for Selected Conditions	Notes
Reporting Periods: Quarterly	
For which conditions did your practice provide condition-specific support for self management in the last quarter? (Select all that apply) ☐ We do not offer self-management support for any conditions <u>Cardiovascular</u> ☐ Congestive Heart Failure (CHF) ☐ Coronary Artery Disease (CAD) ☐ Hyperlipidemia/high cholesterol ☐ Hypertension <u>Respiratory/Pulmonary</u> ☐ Asthma ☐ COPD <u>Mental Health</u> ☐ Anxiety ☐ Depression <u>Substance disorder</u> ☐ Alcohol misuse ☐ Opioid misuse ☐ Tobacco cessation <u>Other</u> ☐ Chronic pain ☐ Obesity/weight Loss ☐ Diabetes ☐ **Other**, please specify: (textbox)	*<u>Note:</u> If you select "We do not offer self-management support," you will be unable to select the other options for this question.* *<u>Note:</u> Prior responses to this question are shown, and only need to be updated.* *To find more information about self-management support, refer to the change concept <u>Integrate self-management support into usual care across conditions</u> (page 61) in Section I of this Guide.*
How do you identify patients for self-management support? (Select all that apply) ☐ We do not systematically identify patients for self-management support ☐ All patients with targeted condition ☐ General risk status (using the practice's risk stratification methodology) ☐ Poorly controlled disease ☐ Data from a formal self-management assessment tool ☐ Patient expression of interest ☐ Clinician referral/identification ☐ Other, please specify: (textbox)	*<u>Note:</u> If you select "We do not systematically identify patients for self-management support," you will be unable to select the other options for this question.* *<u>Note:</u> Prior responses to this question are shown, and only need to be updated.*

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

Activities	Never	Rarely	Some-times	Very often	Always
We encourage patients to choose goals that are meaningful to them					
We include family/caregivers in goal-setting and care plan development					
We connect or provide patients and caregivers with formal self-management support services at our practice or in the community					
We measure patients' skills and progress (e.g., How's My Health, Patient Activation Measure [PAM])					
Our staff are trained in specific self-management support techniques (e.g., motivational interviewing, 5 As, Teach Back, reflective listening)					

Self-management support (SMS) *gives your patients with chronic conditions tools to manage their health on a day-to-day basis and take an active role in their health care. SMS goes beyond supplying patients with information. It develops patient confidence by allowing patients to collaborate with the care team to set goals, regularly assess progress, provide problem solving support, and make plans to live a healthier life.*

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

4.3 Advance Care Planning **Reporting Periods: Quarters 2 and 4**	**Notes**
Requirements differ between start year and track. Please refer to the care delivery requirements for 2017 Starters and for 2018 Starters for clarification.	
Who at your practice is/are typically involved in advance care planning? (Select all that apply) ☐ We do not provide advance care planning ☐ Practitioners (MD/DO, NP, PA) ☐ Other clinical staff (RN, LPN, MA, care manager) ☐ Other non-clinical members of the care team (e.g., administrative or front office staff) ☐ Other, please specify: (textbox)	***Advance care planning*** *(ACP) assists patients to make plans about the care they would want to receive if they became unable to speak for themselves.* *You may also consider staff involved in activities not immediately related to engaging patients in advance care planning. For example, staff members who are not responsible for engaging patients in a conversation, but assist in identifying patients who have not yet started advance care planning may be considered "involved" in the process at your practice.* *Note: If you select "We do not provide advance care planning," you will be unable to select the other options for this question, and the remaining questions for this section are automatically skipped.* *To find more information about staff roles in advance care planning, please refer to the change concept Partner with patients and caregivers in advance care planning (page 66) in Section I of this Guide.*
How does your practice identify patients for advance care planning? (Select all that apply) ☐ We do not systematically identify patients for advance care planning ☐ High-risk status (using the practice's two-step risk stratification methodology) ☐ Patients with serious illness and/or based on age (e.g., cancer diagnosis, end-stage kidney disease, heart failure, COPD) ☐ Clinician or care team referral/identification ☐ Other, please specify: (textbox)	*Note: If you select "We do not systematically identify patients for advance care planning," you will be unable to select the other options for this question.*

As part of advance care planning conversations, do clinicians and staff… (Select all that apply) ☐ Address the patient's values, goals, or care preferences at the end of life ☐ Determine patient designation of health care surrogate or proxy ☐ Assist patients in understanding and completing relevant documents (e.g., advanced directives, POLST/MOLST forms, health care power of attorney) ☐ Other, please specify: (textbox)	
What system(s) do you use to document and store advance care planning conversations and decisions? (Select all that apply) ☐ We do not document and store advance care planning conversations and decisions ☐ EHR or other health IT ☐ A local or regional Health Information Exchange ☐ Patient portal/patient health record ☐ Other, please specify: (textbox)	*Note: The choice "EHR or other health IT" includes scanning and storing paper documents into your EHR.*

Function 5: Planned Care and Population Health

5.1 Team-Based Care **Reporting Periods: Quarters 1 and 3**	Notes
The intent of this section is to learn more about your practice's progress in establishing a team-based care approach to patient care.	
How often do care teams at your practice have structured huddles focused on patient care? ○ Never ○ Only as needed or ad hoc ○ At least daily ○ At least weekly ○ At least every 2 weeks ○ At least monthly	*The intent of this question is to better understand how your care team communicates with each other about coordinating and improving planned patient care, not about quality improvement (QI) goals. This question includes all huddles regarding patient care that occur between members of your care team, even if every member is not included.* *To find more information about team-based care, refer to the change concept Use team-based care to meet patient needs efficiently (page 70) in Section I of this Guide.*
How often do care teams at your practice have scheduled care team meetings to discuss high-risk patients and planned care? ○ Never ○ Only as needed or ad hoc ○ At least daily ○ At least weekly ○ At least every 2 weeks ○ At least monthly	
How often are the following clinical activities delegated to members of the care team (e.g., RN, MA, front desk or other practice staff) other than the practitioner)?	

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

How often do care teams at your practice meet and review quality improvement data (e.g., data on quality, cost, utilization, patient experience of care)? ○ Never ○ Only as needed or ad hoc ○ At least weekly ○ At least monthly ○ At least quarterly ○ At least annually	*Note: Meetings focused on reviewing quality improvement data are different from regular exchanges on patient care such as huddles and planned care meetings.* *Note: If you select "Never," you will be unable to select the other options for this question.*

5.2 Use of Data to Plan Care	Notes
Reporting Periods: Quarters 2 and 4	
Tell us about how you use data on quality, utilization, patient experience, and other measures. We will ask you the following three questions for each type of data (listed below the questions). **At what level is this data available?** ○ Not available ○ Practice level ○ Care team or panel level ○ Both the practice and the care team/panel level **How frequently do care teams review this data?** ○ We do not regularly review this data ○ At least weekly ○ At least monthly ○ At least quarterly ○ At least annually ○ Other, please specify: (textbox) **How helpful are these data** (list below) **in quality improvement or population health work at your practice?** (Rate from 1-5, with 5 being the most helpful and 1 being not helpful at all) List of data sources: • Electronic clinical quality measures (eCQMs) • Claims data feedback from CMS • Claims data feedback from other payers • Patient experience data • Patient-Reported Outcome Measures (PROMs) • Multi-payer data from Health Information Exchange (HIE), all payer claims databases (APCD), or other data aggregator • Public health data from county or state government • Internal practice or system data • Other, please specify: (textbox)	*A **Patient-Reported Outcome Measure (PROM)** is an instrument, scale, or single item measure that is obtained directly from patient self-reporting and used to track experience and quality of care, identify gaps in care, and focus quality improvement activities. PROMs can screen for and capture a patient's reported clinical outcomes for some common, disease-agnostic, and medical/social problems.* *Examples of PROMs include PHQ-2 and PHQ-9 for depression, patient-specific functional pain scales, and quality of life scales.* *Note: "Internal practice or system data" refers to internal organizational data and is distinct from eCQM data or other external feedback data.* *To find more information about using data to improve care, refer to the change concept Measure and improve quality at the practice and panel level (page 91) in Section I of this Guide.*

5.3 Continuous Quality Improvement	Notes
Reporting Periods: Quarters 2 and 4	
Identify the CPC+ measures on which your practice **focused its quality improvement efforts** during the past two quarters. (Select all that apply) ☐ We have not focused quality improvement efforts on any of the CPC+ measures below eCQMs ☐ Controlling High Blood Pressure ☐ Diabetes: Hemoglobin HbA1c Poor Control (>9%) ☐ Diabetes: Eye Exam ☐ Diabetes: Medical Attention for Nephropathy ☐ Dementia: Cognitive Assessment ☐ Depression Utilization of the PHQ-9 Tool ☐ Preventive Care and Screening: Screening for Depression and Follow-Up Plan ☐ Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention ☐ Initiation and Engagement of Alcohol and Other Drug Dependence Treatment ☐ Falls: Screening for Future Falls Risk ☐ Breast Cancer Screening ☐ Cervical Cancer Screening ☐ Colorectal Cancer Screening ☐ Preventive Care and Screening: Influenza Immunization ☐ Pneumococcal Vaccination Status for Older Adults ☐ Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet ☐ Statin Therapy for the Prevention and Treatment of Cardiovascular Disease ☐ Closing the Referral Loop: Receipt of Specialist Report ☐ Other, please specify: (textbox) Utilization and cost ☐ ED ☐ Post-acute care ☐ Inpatient ☐ Observation stays ☐ Specialty care ☐ Other, please specify: (textbox) ☐ Imaging/labs Patient Experience (CAHPS domains) ☐ Getting timely appointments, care, and information ☐ How well practitioners communicate with patients ☐ Overall practitioner ratings ☐ Attention to care from other practitioners ☐ Practitioners support patients in taking care of own health ☐ Other, please specify: (textbox)	*The intent of this question is not to choose all of the eCQMs you will submit for your annual eCQM reporting, but to tell us which you have focused quality improvement efforts on in the last two quarters.* *Find more information about continuous quality improvement, refer to the change concept Measure and improve quality at the practice and panel level (page 91) in Section I of this Guide.*

Why are these measures high-priority areas? (Select all that apply)

- ☐ High volume of patients
- ☐ High-risk population
- ☐ Poor performance or outcomes
- ☐ High cost or utilization in this area
- ☐ Patient feedback
- ☐ Payment incentive from payers
- ☐ Other, please specify: (textbox)

The intent of this question is to better understand how your practice chose the eCQMs and other quality improvement measures listed above as focus areas.

5.4 Culture of Improvement at Your Practice

Reporting Periods: Quarters 2 and 4

Notes

Over the last two quarters, who in your practice…

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

*A **designated quality improvement team** is a group of people within the practice whose role specifically involves implementing quality improvement efforts. Individuals on the quality improvement team may overlap with clinical staff on care teams.*

General Information

CPC+ Payer Partners **Reporting Periods: Quarterly**	Notes
Below are the CPC+ payer partners in your region. Please indicate with which payer(s) your practice has a contractual agreement to receive CPC+ payments that support your CPC+ practice transformation activities and care for your patients.	*Note: When you are in the CPC+ Practice Portal, you will see the list of CPC+ payer partners in your region.* *Note: Prior responses to this question are shown, and only need to be updated.*

Payment Composition Selection and Attribution **Reporting Periods: Quarter 3**	Notes
Select your CPCP%/FFS% for PY 2019 among the options below. Track 2 Payment Options for PY 2019 (CPCP%/FFS%): ○ 25%/75% [Note: This option is only allowable for 2018 Starters in PY 2019] ○ 40%/60% ○ 65%/35%	***"CPCP%"** means the percentage of expected Evaluation & Management Services furnished by participating CPC+ practitioners that your practice elects to be paid in the form of the Comprehensive Primary Care Payment (CPCP). By selecting a CPCP%, your CPC+ Track 2 practice accepts this selection for all practitioners on your CPC+ practitioner roster for CPC+ PY 2019. Please note that CPC+ practices must increase the selected CPCP% each program year until the CPCP% is 40% or 65% by the 3rd program year. To view your practice's CPCP%/FFS% for PY 2018, please refer to the Payment and Attribution tab.* *Note: This question is for **Track 2** CPC+ practices only. The CPCP is intended to support flexible delivery of care beyond traditional office visits.* *For PY 2019, 2017 Starters must select either 40% or 65% CPCP%. Only 2018 Starters may select the 25% option. You may not decrease the CPCP% from what your practice selected in the prior year; for example, if you selected 65% CPCP for PY 2018, you may not move to the 40% CPCP option for PY 2019.* *For more information, please refer to the CPC+ Payment Methodologies paper.*

Patient Demographics	Notes
Reporting Periods: Quarter 4	

The intent of this section is to understand the patients who receive care at CPC+ practices, and to update our records. Exact counts for patient demographics are not necessary. You can use your best estimates for the following questions on patient demographics, if automated data are not available

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

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

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

Note: You will be required to use any numerical value between 0-100, and the percentages must add up to 100 percent.

Is this based on collected data or best estimate?

- ○ Collected
- ○ Best estimate

Note: This question refers to the previous table on patient demographics.

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

CPC+ Program Questions	Notes
Reporting Periods: Quarterly	
Tell us how useful your practice finds each type of communication for CPC+ information and updates. (Rate from 1-5, with 5 being very useful and 1 being not useful at all) (**Optional)** ○ *On the Plus Side* weekly newsletter ○ CPC+ Connect (social media platform) ○ Practice Facilitator or regional learning network email ○ CPC+ Support ○ Learning sessions, Action Groups, Practices in Action, and webinars ○ Other, please specify: (textbox) Please estimate the number of hours your practice spent collecting and inputting data for your care delivery information this quarter. Please round to the nearest whole hour increment. (textbox)	
Reporting Point of Contact	**Notes**
Reporting Periods: Quarterly	

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

Financial Reporting Overview

For financial reporting, you will find information and resources to help you predict and forecast how your practice will use the enhanced payments, report your practice's financial information in the 4th Quarter (Q4) of each calendar year, and reconcile your forecast with your practice's actual expenditures. The information you collect and provide is incredibly valuable because it allows you to track your practice's progress and determine how to deliver the most impact to your patient population.

As a CPC+ participant, your practice will be accountable for providing annual financial forecasts and reconciliations for how you used the enhanced payments made available through CPC+ to improve care delivery. Financial reporting is an integral and required part of your participation in CPC+. Financial reporting is intended to help your practice think strategically about your CPC+ revenue and how best to target your investments to support care delivery transformation.

- You will provide a retrospective report of actual PY 2018 revenues and expenditures. You will report attributed lives and revenues by payer, and expenditures.
- In the forecast, you will tell us what funding you expect to receive in 2019, and how you plan to spend it to support CPC+ activities (attributed lives, revenues, and expenditures). Forecasting is intended to help you understand and optimally plan your use of these funds, and will not be subject to auditing or monitoring.

There are two components to reporting that will structure both your financial forecast and your actuals:

- **Revenue.** To create an effective budget, you must first determine how much revenue your practice received. You are only required to report revenue details for CPC+-related revenues that you receive from CMS and CPC+ payer partners. You will also provide your total revenue for the year, including all income sources (not limited to additional CPC+ revenue); however, you will not need to itemize this revenue or provide additional details to CMS. After reporting historical revenue, you will forecast revenue for the upcoming program year.
- **Expenditures.** Expenditures refers to all expenses incurred by your practice in the last year. For CPC+ financial reporting, you will report the approximate clinical labor, non-clinical labor, and non-labor expenses related to carrying out CPC+ activities in the last year. You will also forecast these expenses for the upcoming program year.

As you report your forecasted revenue and expenditures in the same categories as your practice's actuals, you can make comparisons between your actual expenses and your estimated forecast. This will help you to reflect on your work in the past year and help you to continue to refine your forecast for the next calendar year. The reporting worksheet template, guidance, and fact sheet will help you prepare for reporting and track your CPC+ financial activities.

We recommend you track care management fee (CMF) and Comprehensive Primary Care Payment (CPCP) revenues, and related expenditures, from all payer partners throughout the year to prepare for reporting; however, financial reporting will only take place in Q4 of each calendar year. This reporting includes submission of your forecasted amounts for the following calendar year and submission of your actuals for the preceding calendar year. You will perform these reporting activities via the CPC+ Practice Portal, and must complete your reporting by December 31 annually. You can find detailed guidance on how to complete your financial reporting in the CPC+ Practice Portal in the Financial Reporting Guide: How to Submit Your CPC+ Financial Reporting.

As part of your financial reporting, you will be asked to attest that your practice has complied with all rules regarding use of CPC+ funds paid by CMS. Although you will not be required to submit detailed calculations on how to determine labor costs and other CPC+ related expenditures, you will need to retain this documentation in the event of an audit. To best prepare for financial reporting, you can access the following resources:

- Financial Reporting Guide: How to Submit Your CPC+ Financial Reporting
- Financial Reporting Worksheet
- *What You Need to Know About Financial Reporting* webinar
- *Financial Reporting in the CPC+ Practice Portal* webinar

CPC+ Financial Reporting Guide (as of December 2017)

Introduction

This document guides you through Comprehensive Primary Care Plus (CPC+) financial reporting. Your practice should use this Guide to prepare for reporting and to identify what information you will need to collect and track to smoothly and successfully complete your financial reporting. Within this reporting guide, you will find a preview of what you will need to report later this year, with instructions and definitions for completing it. We recommend you review these materials completely before you begin tracking your revenue and expenditures. Some questions may require input from different staff members in your practice, so please familiarize yourself with all the requirements before you begin.

Available on CPC+ Connect is a supplementary Microsoft Excel®-based workbook to help you document and calculate the CPC+ expenses that you will report; this workbook is only a template and you should modify it to suit your own practice's needs. You are not required to use the workbook; however, if you would like to, it is available for download from CPC+ Connect. You will report both your practice's financial forecast and your actual revenue and expenses in the CPC+ Practice Portal (https://portal.cms.gov).

Financial reporting is an integral and required part of your participation in CPC+. The information you collect and provide in your financial report is incredibly valuable: it allows you to track your CPC+ revenue and expenditures, and to identify what portion of your practice's overall budget goes toward "CPC+ work." It also allows us to understand what resources are needed to support practice transformation through CPC+, and measure the level of additional revenue you receive from CMS and payer partners.

There are two components to financial reporting:

1. **Revenue.** To create an effective budget, you must first determine how much revenue your practice receives. You are only required to report revenue details for CPC+-related revenues that you receive from CMS and CPC+ payer partners. You will also provide us with your total revenue for the year, including all income sources (not limited to additional CPC+ revenue); however, you will not need to itemize this revenue or provide additional details to CMS.
2. **Expenditures.** Expenditures refers to all expenses incurred by your practice in the last year. For CPC+ financial reporting, you will report the approximate clinical labor, non-clinical labor, and non-labor expenses related to carrying out CPC+ activities in the last year. If helpful, you can use the supplemental workbook to separate your CPC+ expenses from overall expenses.

For CPC+ financial reporting, you report on a calendar year basis. For your own practice's tracking and budgeting, you may already use or wish to begin using a monthly budget to better monitor and plan your practice's finances.

Financial reporting in CPC+ is a two-step process.

1. You will ***report*** your practice's actuals, which include attributed lives, revenues, and expenditures.

2. You will ***forecast*** your practice's attributed lives, revenues, and expenditures.

> ***Note*:** You must maintain adequate documentation for your reported actual revenue and expenses in the event of an audit. CMS will not audit your practice's forecast, and your practice will not be monitored based on whether or not your actual expenses match your forecast. The forecast is intended to be a budgeting and learning tool for your practice.

Over the course of the year, you need to keep track of your actual expenses incurred during the year and group them into the categories we ask you to report on. We recommend tracking expenses for both labor and non-labor resources throughout the year to improve the accuracy and ease of your reporting.

The comparison between your actual expenses and your estimated forecast will help you to reflect on your CPC+ work in the past year, and also help you refine your forecast for the next calendar year.

In the same way that your care delivery work is done at the practice-level, you will report your financial expenditures and revenues at the practice-level only. You will not need to allocate resources at the patient-level.

These CPC+ financial reporting activities are intended to help you think strategically about your practice's new revenue and how best to target your investments. To accomplish your practice's goals using enhanced payment from CPC+ and to improve your practice's ability to provide patient-centered, high-quality, cost-effective care for patients and families, you should focus on using accounting best practices to accurately reflect the comprehensive primary care delivered. To ensure you allocate your practice's revenue to developing capabilities you deem to be highest priority areas, you should use past and present data to forecast the payments you will receive under CPC+ for each program year. Then, you should review and prioritize each year's requirements and think about what work and investments your practice needs to do to meet those goals. These findings will help you understand how to allocate resources toward those changes.

Because you know your current practice resources and patient population best, we recommend you utilize CPC+ financial resources in a way that best address the needs of your patient population. This exercise gives us insight into where you are investing your resources to make changes in your practice that lead to the CPC+ aims.

CMS uses the information you provide through your financial reporting in several ways.

- First and foremost, your financial reporting helps us understand how the resources provided through CPC+ are used to fund new and innovative types of work.
- We use the information you provide to identify which areas of work require the most support, which helps us better understand the changes occurring in your practice and helps us improve the practice supports provided through CPC+.
- CMS also uses the information in your annual report of actual attributed lives, revenue, and expenses as part of the materials gathered by the CPC+ auditor.
- These data will only be viewed in an identifiable way by CMS and our contractors. We may publicly share aggregated data rolled up to the region or national level for communication purposes.

Example of How to Identify Priorities and Allocate CPC+ Spending

Requirement: 2.1 Risk stratify all empaneled patients

Types of Questions to Consider:

- Do you need to hire additional staff to carry out this work? If so, do you need a full-time or a part-time individual?
- If you currently have the right staff at your practice, do you need to provide them with additional training to develop the skills to do this work? If so, consider the time it will take to participate in those trainings in addition to the cost of trainings and webinars themselves (if any).
- Is your electronic health record (EHR) or other health information technology (IT) product capable of producing reports to track high-risk patients? Do you need to invest in additional IT upgrades or resources?
- How much time will it take for your practice design and implement your risk-stratification approach? Are other practices doing this in an efficient, cost-effective way that you can adopt?

Reporting Schedule

For the first CPC+ program year (2017), you only need to report your actual practice revenue and CPC+ expenses. In future years, you will complete a forecast at the beginning of the year and actual revenue and expenses at the end of the year (see Figure 4). The PY 2017 expenditure reporting exercise should help you to forecast your expenditures for future years.

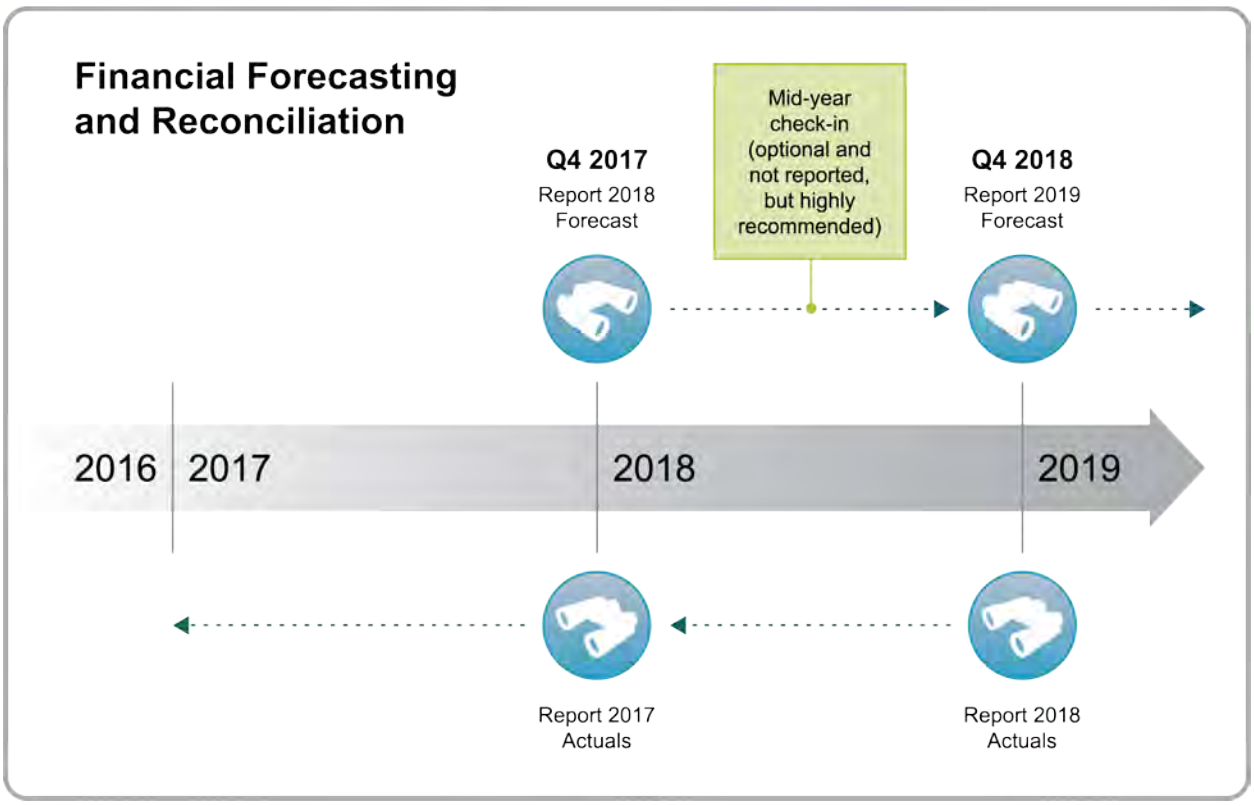

Figure 4. CPC+ Financial Reporting Timeline

Definitions

Table 13 provides definitions for terms used in the CPC+ financial reporting.

Table 13. CPC+ Financial Reporting Terms and Definitions

Revenue Terms	
Terms	**Definition**
Payers	All CPC+ payer partners from your region will be prepopulated. You should only enter payments from the payers with which you contract under their respective CPC+-aligned program. For example, if you contract with a payer in your region, but that payer is not paying you enhanced CPC+ payments for its members at your practice, you should enter 0 in the lines for this payer.
Attributed patients	Attributed patients are the patients in your practice for whom a CPC+ payer partner pays you enhanced support through that payer's CPC+ program. Medicare will prepopulate your Medicare fee-for-service (FFS) attributed patients, based on the total unique patients attributed throughout the year. You will need to enter the amounts for the CPC+ payer partners, including Medicaid. We recommend that you use the number of attributed patients per payer at a single point in time, rather than trying to calculate the number of unique patients attributed throughout the year.

Terms	Definition
Care management fees (CMFs)	CMFs are the non-visit based payments that you receive from Medicare FFS and CPC+ payer partners to provide wrap-around services to your patients. Medicare will prepopulate the Medicare CMFs your practice receives. The support you enter in this category should be payments your practice receives that are in addition to payments for services provided.
Medicare Fee-for-Service (FFS)	Medicare FFS is Original Medicare, and includes the revenue generated by billing for services through Medicare Part A and Part B. Medicare FFS is with whom your practice signed the Participation Agreement and that pays the Medicare CPC+ payments.
Alternative to FFS payments or FFS alternative payments	Alternative to FFS payments are the payments you receive from Medicare and CPC+ payer partners that are intended to replace or move away from traditional FFS revenue. For example, the Comprehensive Primary Care Payment (CPCP) for Track 2 practices is CMS' alternative to FFS payment. Other payer partners may provide a CPCP-like payment or global payments, or may have made increases to the capitated payments that your practice already received. If you do not receive any FFS alternative payments from a payer, you should enter 0.
Total practice revenue	Total practice revenue is the total amount of income your practice takes in during the year. This figure should include all CPC+ revenues (non-visit based payment and alternatives to FFS) and other revenue, such as FFS payment, grants or awards, and any performance-based bonus or incentive payments that your practice kept. We use this information to understand the relative impact of CPC+ on your practice's revenue. Only CMS and our contractors can see this information; we will not share individual practice revenue information with others.

Expenditure Terms	
Terms	**Definition**
Non-labor expenditures	Non-labor expenditures are your practice expenses that are not tied to a staff member. We have listed the most common categories below; however, we know practices have many different types of expenses, so we have left you room to add additional non-labor expenses. Note that your CPC+ expenditures should reflect all CPC+ income, not just income received from Medicare FFS. • Facilities – These include your office expenses, such as rent and equipment costs. • Supplies – These include other operating expenses at your practice, such as for printing, postage, etc. • Trainings, Travel, and Conferences • Consulting Fees • Health IT Equipment and Maintenance – These expenses should include your electronic health record (EHR) and any health IT services your practice contracts for, as well as maintenance for those products. Although you cannot use Medicare CMFs to pay for health IT, you may use other sources of revenue. • Non-Health IT Technology – These are costs associated with technology aside from your EHR and other health IT costs. • Depreciation Expenses – Depreciation costs are associated with capital purchases made by your practice. Your practice should follow best practices for depreciating its applicable fixed assets (e.g., building, furniture, software, equipment). • Other

Terms	Definition

Labor expenditures	Labor expenditures are your practice expenses for hired, contracted, or consultant staff time. We have listed categories below to help categorize your practice staffs' time by type staff member and type of activity. If your practice receives support from centralized or shared staff, please include your practice's portion of the total cost. We understand that these are **estimates** and will likely vary from week to week. We ask that you do your best to provide a snapshot of the labor-related expenses in an "average" week at your practice.
	• Staff types
	  o Clinical staff – This category includes all members of your staff involved in providing direct clinical care to your patients. It could include physicians (Doctor of Medicine/Doctor of Osteopathic Medicine [MD/DO]), Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs), Physician Assistants (PAs), Registered Nurses (RNs), Medical Assistants (MAs), Licensed Practical Nurses (LPNs), or any other staff type involved in the clinical care of patients.
	  ▪ Please include designated care managers at your practice in the group that best matches their licensing, rather than their role or job title (e.g., a nurse care manager should be accounted for under the RN category).
	  o Non-clinical staff – This category includes all members of your staff who are not involved in providing clinical care. It could include office managers or administrators, front office staff, schedulers, data analysts, or any other non-clinical staff members who work on CPC+.
	• Labor categories
	  o Clinical Care
	  ▪ Traditional visits – Regular FFS patient visits, typically provided in an office setting. This category refers to direct patient care you provide in person and in the office.
	  ▪ Alternative visits – Care delivered outside the traditional office visit. Track 2 practices may use their CPCPs to support this work. Depending on the needs of your patient population, this category could include (but is not limited to) e-visits, phone visits, group visits, home visits, and alternate location visits (e.g., at senior centers and assisted living centers).
	  ▪ Care management – Traditionally non-billable, wrap-around services that are patient-facing, such as those your practice provides for patients with high or rising risk during transitions of care, as well as for tracking and closing the referral loop for patients referred outside the practice and other related activities.
	  o Administrative
	  ▪ Team activities and meetings – Team huddles and meetings to plan care, review patient care processes, address gaps in planned care and population health, and conduct quality improvement (QI) work. In addition, because patients and caregivers on your Patient and Family Advisory Council (PFAC) are a part of your team, this category includes your PFAC meetings and activities related to convening PFAC meetings.

Terms	Definition
Labor expenditures (continued)	▪ Care coordination – Non-patient facing activities your practice does to create and maintain a medical neighborhood and to identify resources and supports to meet patients' psychosocial needs, such as establishing relationships with local hospitals or setting up a care compact with specialists. Note that this category does not include patient-facing activities related to coordination of care; rather, it is limited to the time your practice spent establishing a care coordination system and network. ▪ Quality Improvement & Data Analysis – This category includes activities related to planning and implementing QI at your practice. This includes data analytics, reviewing electronic clinical quality measures (eCQMs) and other payer data feedback, and other related work. ▪ Other CPC+ Activities – This category includes any other activities your practice may do as a result of your participation in CPC+. ▪ Non-CPC+ Activities – Office operations work and any other non-clinical activities that your practice carries out. This category includes activities that existed in your practice prior to CPC+ implementation that do not change as a result of CPC+, such as managing your office's lease, ordering or maintaining supplies, or other general office management activities.

Instructions

In Quarter 4 (Q4) of each calendar year, you will submit your forecasted amounts for the following calendar year, entering amounts in all cells shown in blue. During Q4 reporting each year, you will submit your actuals for the preceding calendar year, for the same fields. Gray cells will auto-calculate based on the values you entered in the blue cells. We have shown only one column for each field for simplicity.

Revenue Section		
Line	**Description**	**Notes**
Lines i-xii	Revenues and Attributed Lives by CPC+ Payer a. Number of attributed beneficiary months for each payer listed b. Total care management fees (CMFs) c. Total fee-for-service (FFS) alternative payments (this includes the Comprehensive Primary Care Payment (CPCP) from Medicare FFS for Track 2 practices and aligned payments from payer partners). ***Note:*** These alternative payments should exclude any at-risk revenue, such as shared savings, the Performance-based Incentive Payment (PBIP), and any other revenue that is conditioned on meeting quality/utilization/efficiency or other metrics or is subject to recoupment	*Please provide the following information for **each** of your CPC+ payers. The CPC+ payer partners in your region will be pre-populated in this form; we have provided a few payer names as illustrative examples only.* *Reminder: You should only enter payments from the payers with whom you contract under their respective CPC+-aligned program.*

Revenue Section		
Line	**Description**	**Notes**
Line 1	Total Practice Revenue	*Please enter here all the revenue your practice earns in the calendar year. If applicable, include all other revenue types, such as grants, FFS revenue, shared savings, and any other bonus payments.*
Line 2	Total Active Lives	*Please enter here the total number of patients at your practice, including all CPC+ attributed patients, non-attributed patients, and uninsured patients.*
Line 3	Total Attributed Patients	*This cell will auto-calculate.*
Line 4	Total CPC+ Revenue	*This cell will auto-calculate.*
Line 5	Percentage of revenue from CPC+	*This cell will auto-calculate, based on Line 4 divided by Line 1.*
Line 6	Percentage of patients attributed to a CPC+ payer	*This cell will auto-calculate, based on Line 3 divided by Line 2.*

Expenditures Section		
Line	**Description**	**Notes**
Lines 7-14	Non-Labor Expenses	*Enter your practice's total expenditures for non-labor resources used for CPC+ work in the categories indicated, as well as what portion of that expense was specifically for CPC+. The CPC+ portion may be equivalent to the Total Amount, or may be none of it.*
Line 15	Total Non-Labor Expenditures	*This cell will auto-calculate.*

Expenditures Section		Notes
Line	**Description**	
Lines 16-18	Clinical Care Activities	*Please enter your practice expenses for clinical care activities, separated by type of staff. To allocate these expenses, the attached workbook allows you to track, by individual, the estimated average weekly hours spent on each activity, and guides you through calculating the total expenditures by staff type (rather than individual).*
Lines 19-22	Administrative Activities	*Please enter your practice expenses for administrative activities, separated by type of staff. To allocate these expenses, the attached workbook allows you to track, by individual, the estimated average weekly hours spent on each activity, and guides you through calculating the total expenditures by staff type (rather than individual).*
Line 23	Non-CPC+ Activities	*Please enter your practice expenses for all other practice activities not accounted for in lines 15-21.*
Line 24	Total Labor Expenditures	*This cell will auto-calculate.*
Line 25	Total CPC+ Revenue	*This cell will auto-populate from Line 4 above.*
Line 26	Total CPC+ Expenditures	*This cell will auto-populate, based on the sum of lines 15 and 24, excluding columns for labor expenses related to Traditional Visits and Non-CPC+ Activities.*

Financial Reporting through the CPC+ Practice Portal

Example values are shown in italics. As described above, you will report these fields for a given calendar year at two points: first as your practice's actual attributed lives, revenues, and expenditures and then as a prospective forecast. You will see your actuals and forecast for the same year side-by-side in the CPC+ Practice Portal. We have shown only one set of reporting here for simplicity.

CPC+ Revenues

Line	Payer	Payer Name	Account	Amount
i	Payer #1	Medicare FFS	Attributed Patients	*$ 600*
ii	Payer #1	Medicare FFS	Care Management Fees	*$ 201,600*
iii	Payer #1	Medicare FFS	FFS Alternative Payments	*$ 10,300*
iv	Payer #2	BlueCross BlueShield	Attributed Patients	
v	Payer #2	BlueCross BlueShield	Care Management Fees	$
vi	Payer #2	BlueCross BlueShield	FFS Alternative Payments	$
vii	Payer #3	UnitedHealthcare	Attributed Patients	
viii	Payer #3	UnitedHealthcare	Care Management Fees	$
ix	Payer #3	UnitedHealthcare	FFS Alternative Payments	$
x	Payer #4	Medicaid	Attributed Patients	
xi	Payer #4	Medicaid	Care Management Fees	$
xii	Payer #4	Medicaid	FFS Alternative Payments	$
1	Total Practice Revenue			$
2	Total Active Lives			$
3	**Total CPC+ Attributed Patients**			
4	**Total CPC+ Revenue**			$
5	**% of Revenue from CPC+**			%
6	**% of Patients Attributed to a CPC+ Payer**			%

CPC+ Expenditures

Tip: The Excel-based workbook attached to this reporting guide includes detailed instructions in how to generate your practice's CPC+ expenditures. You do not need to submit your workbook; it is only provided to aid your practice in preparing to report.

Line	Non-Labor Expenses	Total Amount	CPC+ Portion
7	Facilities	$	$
8	Supplies	$	$
9	Training, Travel, and Conferences	$	$
10	Consultant Fees	$	$
11	Health IT Equipment and Maintenance	$	$
12	Non-Health IT Technology	$	$
13	Depreciation Expenses	$	$
14	Other	$	$
15	**Total Non-Labor Expenditures**	$	$

Labor Expenditures			**Clinical Labor**							**Non- Clinical Labor**			
Line	**Total**	MD/ DO	NP/ CNS	PA	RN	MA	LPN	Other Clinical	Admin	IT/ Analytic	Account- ing	Other Non- Clinical
Clinical Care												
16 Traditional Visits	$	$	$	$	$	$	$	$	$	$	$	$
17 Alternative Visits	$	$	$	$	$	$	$	$	$	$	$	$
18 Care Management	$	$	$	$	$	$	$	$	$	$	$	$
Administrative												
19 Team Activities & Meetings	$	$	$	$	$	$	$	$	$	$	$	$
20 Care Coordination	$	$	$	$	$	$	$	$	$	$	$	$
21 Quality Improvement & Data Analysis	$	$	$	$	$	$	$	$	$	$	$	$
22 Other CPC+ Activities	$	$	$	$	$	$	$	$	$	$	$	$
Other												
23 Non-CPC+ Activities	$	$	$	$	$	$	$	$	$	$	$	$
24 Total Labor Expenditures	$	$	$	$	$	$	$	$	$	$	$	$

Summary

You submit your forecasted and actual CPC+ revenue and expenditures at different time periods. When you submit your actual revenues and expenditures, you will see how your actual and forecasted values compare in the Variance column. In 2017, we did not require a forecast; consequently, you will not see any results in the Variance column until you report your practice's forecasted and actual CPC+ revenue and expenditures between the December 2017 – January in 2018 reporting period (timeframes will be different from 2018 Starters).

Line	Item	Actuals	Forecast	Variance
25	**Total CPC+ Revenue**	$	$	$
26	**Total CPC+ Expenditures**	$	$	$

Attestation on Use of Funds

Note: You will submit this attestation in the CPC+ Practice Portal when you report your actual revenue and expenses at the end of each program year. We have provided this language here for your reference only, and you do not need to submit this sheet. For more information, please refer to the Use of CPC+ Funds Section in the CPC+ Frequently Asked Questions - 17th edition.

Note: You will submit this attestation in the CPC+ Practice Portal when you report your actual revenue and expenses at the end of each program year. We have provided this language here for your reference only, and you do not need to submit this sheet. For more information, please refer to the Use of CPC+ Funds Section in the CPC+ Frequently Asked Questions - 17th edition.

I attest that for PY 2017, our practice has complied with all rules regarding use of CPC+ funds paid by CMS. In accordance with section IV.F of the CPC+ Participation Agreement, this practice is not using the CMS care management fees (CMFs) for prohibited expenses, which include, but are not limited to:

- Health IT, including upgrades, and hardware purchased solely for the purpose of accessing health IT
- Income tax payments
- Imaging equipment or other durable medical equipment
- Medications
- Continuing Medical Education (CME) (if not directly related to CPC+)
- Costs (personnel or other costs) related to any practice billing or coding not related to CPC+
- Office space, supplies, or decorations
- Payments to participating CPC+ practitioners for purposes other than supporting work related to CPC+
- Payments to a care management company

Further, as a Track 2 CPC+ practice, I attest we use the Comprehensive Primary Care Payment (CPCP) exclusively to fund the provision of medical care by participating CPC+ practitioners to Medicare beneficiaries, including but not limited to services with asynchronous communication and services performed outside the CPC+ practice site's physical location.

First Name: (textbox)

Last Name: (textbox)

Role at Practice: (textbox)

Timestamp

Section III: Quality Measurement and Reporting

Introduction

This section of the Guide reviews the quality measurement and reporting requirements for CPC+, and defines the performance targets to retain your Performance-based Incentive Payment (PBIP). We also cover the CPC+ quality measures, the reporting requirements for these measures, and how CPC+ requirements align with other CMS quality reporting requirements, namely those of the Quality Payment Program (QPP) and Medicare Shared Savings Program. In this section, you will find resources to help you select the eCQMs your practice will track, use the eCQMs to measure your practice's performance, and instructions on how to report your practice's information.

The success of CPC+ depends on how well CPC+ practices improve and maintain improvements in quality of care throughout the five years of the model. To track quality of care, identify gaps in care, and focus quality improvement activities, CPC+ uses electronic clinical quality measures (eCQMs), utilization measures, and a patient experience of care survey. CMS rewards practices that demonstrate a high quality of care reflected by these measures with a PBIP that matches their performance as discussed in the CPC+ Payment Methodologies Paper. Practices that are dual participants in both CPC+ and the Shared Savings Program are *not* eligible for the PBIP, which is described in the Shared Savings Program and CPC+ Interaction paper.

In addition to these three types of measures, CMS will work with Track 2 practices to develop a patient-reported, outcome-based performance measure (PRO-PM). Development of the PRO-PM is a unique innovation for CPC+ that will aid in practices' better understanding of how to use patient-reported outcomes to capture quality performance. Track 2 practices will receive more information about the CPC+ PRO-PM as it becomes available.

Table 14 shows the quality measurement strategy for each track and the quality measures that affect the amount of PBIP you will receive (the PRO-PM will not affect the amount of PBIP you will receive). Definitions and explanations of key quality measurement terms follow the table.

Table 14: CPC+ Quality Measurement Strategy by Track

Quality Measures	Track 1	Track 2	Affects PBIP
eCQMs	●	●	●
Utilization Measures	●	●	●
Patient Experience of Care Survey. Consumer Assessment of Healthcare Providers & Systems (CAHPS) Clinician and Group Patient-Centered Medical Home Survey	●	●	●
PRO-PM		●	

eCQM Overview

Clinical quality measures (CQMs) are mechanisms used to measure the observations, treatment, processes, experience, and/or outcomes of patient care delivered by providers and hospitals.[53] These measures use data associated with providers' ability to deliver high-quality care or relate to long-term goals for quality health care. CQMs measure many aspects of patient care, including health outcomes, clinical processes, and patient safety. CQMs are reported to CMS to ensure health care systems are delivering effective, safe, efficient, patient-centered, equitable, and timely care.

An electronic clinical quality measure (eCQM) is a clinical quality measure expressed and formatted to use data from electronic health records (EHRs) and other types of health IT to measure health care quality. eCQMs use data captured in a structured form (e.g., data entered into specific fields) during patient care. Certified EHR Technology (CEHRT) systems are the primary sources for eCQMs. eCQMs fit into the CMS Quality Strategy domains of:

- Clinical Processes/Effectiveness
- Care Coordination
- Patient and Caregiver Engagement
- Population and Public Health
- Patient Safety
- Efficient Use of Healthcare Resources

Your practice must choose and successfully report 9 of the 19 measures from the CPC+ eCQM measure set for the 2018 Performance Period (see Table 15 below), which began on January 1, 2018 and ends on December 31, 2018. We selected the 2018 measures using a comprehensive process that took into account:

- Continuity from 2017
- Suitability for primary care
- Coverage of multiple clinical topic areas (including behavioral health)
- Opportunities for improvement
- Resolution of known issues

[53] The Office of the National Coordinator for Health IT. (2013, January 15). What are Clinical Quality Measures? Retrieved from https://www.healthit.gov/providers-professionals/faqs/what-are-clinical-quality-measures#footnote-1

You must select the measures using a two-step process as follows:

- Step 1: Report on both outcome measures.
- Step 2: Select at least seven other measures from the remaining group.

As a requirement of participation in CPC+, all practices must meet eCQM reporting requirements. Standard Participants must meet eCQM reporting requirements to be eligible to earn the PBIP. Standard Participants are those practices that are not also participating in the Medicare Shared Savings Program Dual Participants). Table 15 contains the CPC+ eCQM set for the 2018 Measurement Period. All of these eCQMs are also in the eCQM set finalized for the Merit-based Incentive Payment System (MIPS) that is a part of the QPP. You can find more details on what is required (specifications) for each of these eCQMs in the 2018 eCQM and Health IT Review webinar.

Table 15: 2018 Quality Measure Set

Group 1: Outcome Measures – Report Both Outcome Measures					
Measure Type	**CMS ID#**	**NQF#**	**Measure Title**	**Measure Type/ Data Source**	**Domain**
Outcome Measures	CMS165v6	0018	Controlling High Blood Pressure	Outcome/eCQM	Effective Clinical Care
	CMS122v6	0059	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	Outcome/eCQM	Effective Clinical Care

Group 2: Other Measures – Report At Least 7 Other Measures					
Measure Type	**CMS ID#**	**NQF#**	**Measure Title**	**Measure Type/ Data Source**	**Domain**
Cancer	CMS125v6	2372	Breast Cancer Screening	Process/eCQM	Effective Clinical Care
	CMS130v6	0034	Colorectal Cancer Screening	Process/eCQM	Effective Clinical Care
	CMS124v6	0032	Cervical Cancer Screening	Process/eCQM	Effective Clinical Care
Diabetes	CMS131v6*	0055	Diabetes: Eye Exam	Process/eCQM	Effective Clinical Care
	CMS134v6†	0062	Diabetes: Medical Attention for Nephropathy	Process/eCQM	Effective Clinical Care
Medication Management	CMS156v6	0022	Use of High Risk Medications in the Elderly	Process/eCQM	Patient Safety

Measure Type	CMS ID#	NQF#	Measure Title	Measure Type/ Data Source	Domain
Care Coordination	CMS50v6	N/A	Closing the Referral Loop: Receipt of Specialist Report	Process/eCQM	Communication and Care Coordination
Mental Illness/ Behavioral Health	CMS2v7	0418	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Process/eCQM	Community/ Population Health
	CMS160v6†	0712	Depression Utilization of the PHQ-9 Tool	Process/eCQM	Effective Clinical Care
	CMS149v6	2872	Dementia: Cognitive Assessment	Process/eCQM	Effective Clinical Care
Substance Abuse	CMS138v6	0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Process/eCQM	Community/Population Health
	CMS137v6	0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Process/eCQM	Effective Clinical Care
Safety	CMS139v6	0101	Falls: Screening for Future Fall Risk	Process/eCQM	Patient Safety
Infectious Disease	CMS147v7†	0041	Preventive Care and Screening: Influenza Immunization	Process/eCQM	Community/ Population Health
	CMS127v6†	N/A	Pneumococcal Vaccination Status for Older Adults	Process/eCQM	Community/ Population Health
Cardiovascular Disease	CMS164v6†	0068	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Process/eCQM	Effective Clinical Care
	CMS347v1†§	N/A	Statin Therapy for the Prevention and Treat-ment of Cardiovascular Disease	Process/eCQM	Effective Clinical Care

** Note: eCQM labeled as "topped-out" benchmarks based on the 2017 MIPS definition. For further information, please visit:*
http://www.ascrs.org/sites/default/files/CMS%20QPP%20Benchmarks%20V2_Remediated.pdf

† New to CPC+ in 2018.

§ New to the QPP in 2018.

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

Each reported eCQM must include all data elements (i.e., the numerator, denominator, exclusions, exceptions [if applicable], and performance rates) to meet the requirements. For measures with multiple data elements, practices must report all elements (e.g., two performance rates, two numerators). The performance rate formula is illustrated in Figure 4.

$$\text{Performance Rate} = \frac{\text{Numerator} - \text{Numerator Exclusions}}{\text{Denominator} - \text{Denominator Exclusions} - \text{Denominator Exceptions}}$$

Figure 4: Example of a Performance Rate Formula

For more information on measure specifications, please visit the following link:

- Detailed Measure Specifications

Detailed Value Set Information Utilization Measures

What does your practice need to do for utilization measures?

- Your practice does not need to report anything for these measures. CMS calculates these measures.
- Your practice should engage in the primary care functions that can improve the quality of care reflected in these measures (e.g., care management and care coordination) as described in Section 1: Care Delivery of this Guide.

CMS will assess practice performance on utilization measures. For the 2018 Measurement Period, we will focus on the following two utilization measures from the Healthcare Effectiveness Data and Information Set (HEDIS®):[54]

- Inpatient hospitalization utilization per 1,000 attributed beneficiaries
- Emergency department utilization per 1,000 attributed beneficiaries

There is no reporting requirement for these two measures. CMS and its contractor will calculate these measures at the end of each program year using claims data. Additional information related to how the results of the utilization measures impact the PBIP are described in CPC+ Payment Methodologies: Beneficiary Attribution, Care Management Fee, Performance-based Incentive Payment, and Payment Under the Medicare Physician Fee Schedule (Version 1) (December 1, 2017). Appendix G of the CPC+ Payment Methodologies paper lists the technical specifications for the two utilization measures.

[54] Disclaimer: The Inpatient Hospital Utilization and Emergency Department Utilization measures and specifications were developed by the National Committee for Quality Assurance (NCQA) under the Performance Measurements contract (HHSM-500-2006-00060C) with CMS and are included in HEDIS with permission of CMS. HEDIS measures and specifications are not clinical guidelines, do not establish a standard of medical care and have not been tested for all potential applications. NCQA also makes no representations, warranties or endorsements about the quality of any organization or clinician who uses or reports performance measures. NCQA has no liability to anyone who relies on HEDIS measures and specifications or data reflective of performance under such measures and specifications. Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of any coding contained in the specifications. The American Medical Association holds a copyright to the CPT® codes contained in the measures specifications.

Patient Experience of Care

What does your practice need to do for the patient experience of care survey?

- CMS will ask your practice to provide a roster of all patients that we can use to randomly select participants for the CPC+ Patient Experience of Care Survey. CMS will pay for this survey.
- Your practice should review the topics of the survey and engage in efforts to improve patient experience of care in each of the topics.

Why is measuring patient experience of primary care important? For patients, good experience—particularly with care continuity—is positively associated with patients' engagement with and adherence to medication and other care regimens.[55,56] Better experience in primary care is associated with lower utilization of inpatient and ED services.[56,57] For the practice, measures of patient experience correlate with measures for clinical care processes to prevent and manage disease. Thus, positive reports of patient experience reflects high quality care.[55,58] The survey offers insight into otherwise difficult-to-measure features of care delivery, such as whether patients readily understand the information that your practice is providing, their ease of obtaining after-hours medical advice, or their ability to see practitioners at the appointed time for an office visit.[59] Feedback about patient experience can also help practices set priorities for patient-centered quality improvement initiatives.

While some primary care practitioners may be concerned that efforts to transform quality of care will conflict with patient experience, there is no evidence that this is the case.[60] Furthermore, routine monitoring of measures for both quality processes and patient experience will ensure that if such conflicts arise, your practice can detect and correct them. Research shows the business case for improved patient experience, as it is positively correlated with patient loyalty and retention, reduced medical malpractice risk, and increased employee satisfaction.[55]

CMS will conduct patient experience of care surveys annually with a sample of your patient population. The questions in the CPC+ Patient Experience of Care Survey are taken from

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[55] Browne, K., et al. (2010). Measuring patient experience as a strategy for improving primary care. *Health Affairs.* Retrieved from http://content.healthaffairs.org/content/29/5/921.full.pdf

[56] Saultz, J.W. (2003, September-October). Defining and Measuring Interpersonal Continuity of Care. Retrieved from http://www.hpm.org/Downloads/Bellagio/Articles/Evaluation_and_measurement/Saultz_2003_Defining_Measuring.pdf

[57] Anhang Price, R., et al. (2014, October 1) Examining the role of patient experience surveys in measuring health care quality. Retrieved from http://escholarship.org/uc/item/8746s9d2

[58] Cook, N., et al. (2015, December). Patient Experience in Health Center Medical Homes. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/26026275

[59] Anhang Price, R., et al. (2015). Should health care providers be accountable for patients' care experiences? Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/25416601

[60] Sequist, T.D., et al. (2008 November 23). Quality monitoring of physicians: linking patients' experiences of care to clinical quality and outcomes. *Journal of General Internal Medicine*. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/18752026

existing instruments, such as CG-CAHPS® 3.0 and questions from the initial CPC Classic Initiative. In addition, CMS developed some questions specifically for use in this survey.

CMS will pay for fielding this survey. Your practice is required to provide a patient roster that CMS will use to sample your patient population. For additional information related to how the results of the CPC+ Patient Experience of Care Survey will impact the PBIP, see the *CPC+ Payment Methodologies: Beneficiary Attribution, Care Management Fee, Performance-based Incentive Payment, and Payment Under the Medicare Physician Fee Schedule*. (Appendix E of CPC+ Payment Methodologies paper further discusses the patient survey measures and describes the benchmarking methodology.)

CMS will ask your practice to provide a roster of patients for the patient experience of care survey (CAHPS) that CMS will conduct. CMS will conduct the CAHPS on a sample of patients from the roster that you provided in the spring of the program year. This sample will be the basis of your practice's CAHPS score. The CAHPS score is an important factor that affects whether you receive the full PBIP. For more information, see the eCQM Reporting section below.

To assist practices in understanding their patient engagement and to take action to improve care to address patients' feedback, CMS will provide the results of the patient experience surveys in the quarterly Practice Feedback Reports. There will also be specific learning tailored to assist practices in interpreting and using their survey results.

Table 16 describes the patient experience topics that CMS will review.

Table 16: Measures of Patient Experience

Survey Topics	Items in this topic asks patients whether…
Getting timely appointments, care, and information	They received an appointment for urgent and non-urgent care as soon as needed, and answers to medical questions the same day they contacted your office.
How well providers communicate	You explained things in a way that was easy to understand, listened carefully to them, showed respect for what they had to say, and spent enough time with them.
Attention to Care from Other Providers	You seem informed and up-to-date about the care they got from specialists, or how often you talked with them about all the prescription medicines they were taking.
Shared decision making	You talked to them about their reasons why they might or might not want to take medications, or asked them what they thought was best for them.
Providers support patients in taking care of their own health	You talked to them about specific goals for their health, or asked if there are things that make it hard for them to take care of their health.
Provider rating	Patients' perception of your overall performance as a provider (scale from 0 to 10, worst to best).

What is a Patient-reported Outcome Measure (PROM)? A PROM is a question or set of questions that assess how patients feel and what they are able to do. Patient-reported Outcomes (PROs) are obtained directly from patients through their self-reporting without any filtering or interpretation from others. PROMs can screen for and capture a patient's reported clinical outcomes for some common, disease-agnostic, and medical/social problems, such as depression, problems with physical functioning, social isolation, and pain. The 0-to-10 pain rating scale is an example of a single-item PROM. The Patient Health Questionnaire (PHQ-9) is an example of a patient self-reported screening tool for depression that can also be used to describe change in depression over time.

Are PROMs and CAHPS the same? No, PROMs are distinct from CAHPS in that they ask patients to report on aspects of their health status as opposed to their perception or experience of the care received. This section addresses PROMs. For further information on CAHPS, refer to the Quality Measurement in CPC+: Patient Experience of Care section above.

What is a PRO-PM and how is it different from a PROM? A PRO-PM is a performance measure *based on PROM data* that CMS aggregate for an accountable health care entity.

How will PRO-PMs be rolled out to Track 2 practices? The ultimate goal is to use one or more PRO-PMs to assess performance of Track 2 practices in the later years of CPC+. However, initially, CMS will work with practices to pilot test one or more PROMs to:

- Guide medical care and care management for patients with complex needs
- Implement efficient, practical, and clinically useful ways to collect and report PROM data for practice
- Determine how best to calculate the PRO-PMs that will be derived from the PROM data

To that end, CMS will select one or more PROMs that practices can use later in program years. Practice representatives will contribute to this selection process through their participation in practice focus groups. We will keep you informed of progress toward this requirement.

eCQM Reporting

What does your practice need to do for eCQMs in 2018?

- Choose 9 of the 19 eCQMs in the set for 2018 Measurement Period (both outcome measures plus 7 of the remaining 17 measures) (Table 15).
- Check with your EHR or health IT vendor to ensure it can report the nine selected CPC+ eCQMs at the practice site level.
- Update your practice's vendor roster on the **Health IT Details** tab in the CPC+ Practice Portal. Follow the instructions in the CPC+ 2017 Practice Portal Health IT User Guide to enter your updates.
- Select at least three eCQMs for your quality improvement efforts. This is a CPC+ requirement.
- Monitor your eCQM performance at least quarterly for the nine selected measures. This is not required for CPC+, but is strongly recommended.
- Report eCQMs during the Submission Period of January 1–February 28, 2019.
- Include all required data elements (i.e., numerators, denominators, exclusions, exceptions, and performance rates) for eCQMs when reporting them.

CPC+ practices in both tracks must ensure they can generate an eCQM report using certified health IT that filters the quality measure data at the CPC+ Practice Site location and CPC+ Tax Identification Number (TIN)/National Provider Identifier(s)(NPI[s]) level. In many cases, this reporting is performed by the CEHRT that a practice already uses; however, some practices may adopt additional certified health IT to meet these requirements, such as a registry that is certified to the criteria at 45 CFR 170.315 (c)(1)-(c)(3) for each quality measure.

In addition, **no later than December 31, 2018**, practices must adopt and maintain certified health IT that meets the 2015 Edition certification criterion found at 45 CFR 170.315(c)(4). The (c)(4) criterion enables CPC+ practices to filter eCQMs for reporting at the practice site level. While practices have until December 31, 2018 to have access to technology that meets the (c)(4) filter certification, CMS expects practices to have access to technology that meets the CPC+ practice-site level reporting requirements during the program year. Figure 6 describes these differences in detail.

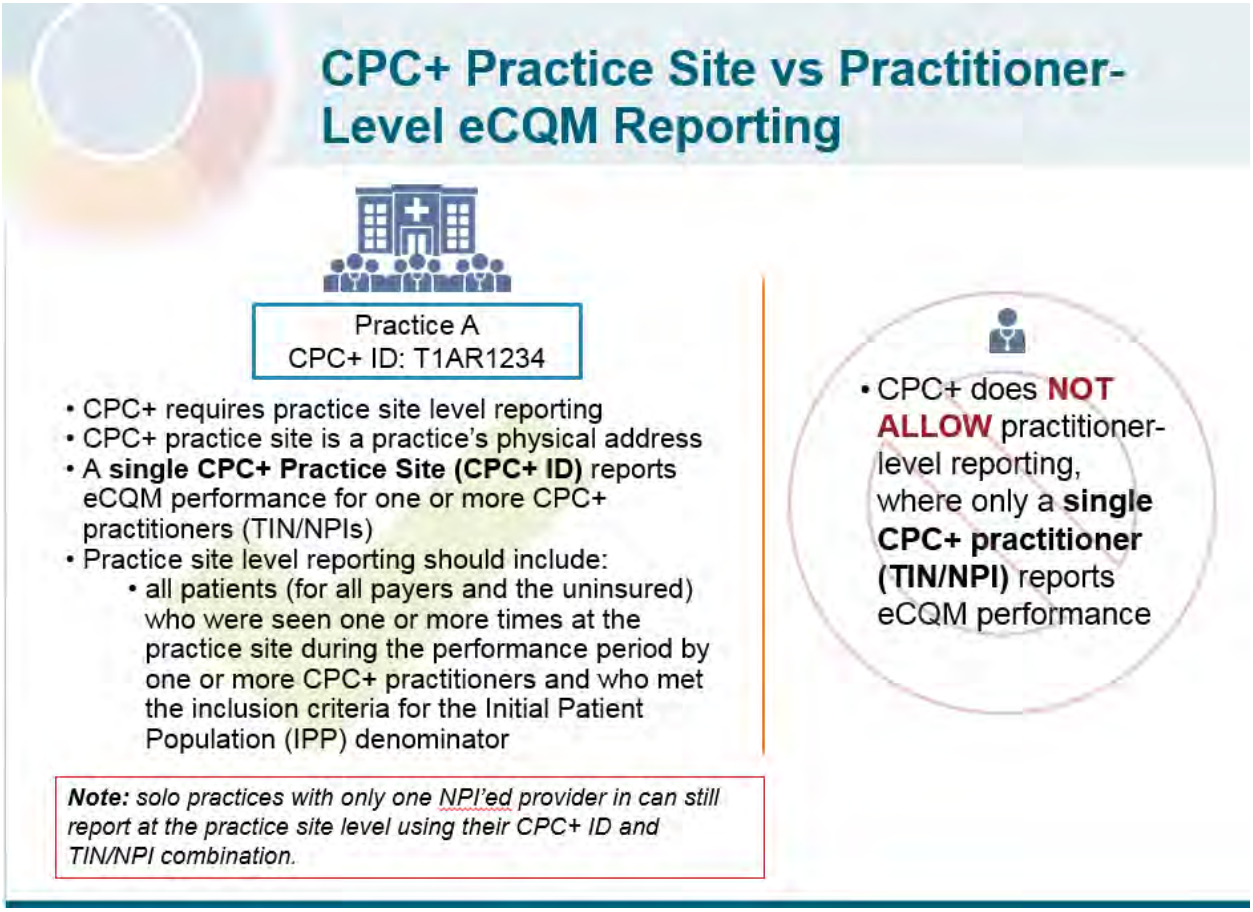


Figure 6: CPC+ Practice Site vs. Practitioner-Level eCQM Reporting

CMS requires practices to report eCQMs at the CPC+ Practice Site level. Practice site-level reporting reflects the quality of care provided by the CPC+ practice and should include all patients (from all payers, as well as the uninsured) who were seen one or more times at the practice site location during the measurement period by one or more CPC+ clinicians (identified by TIN and NPI[s]).

Each practice accepted into CPC+ has a separate geographic location with a unique CPC+ ID. Larger organizations with multiple practice sites and locations should have a unique CPC+ ID for each physical location, unless these locations are satellite offices. CPC+ defines the practice location as the physical address (i.e., street address, suite number, city, state, and ZIP Code) of the CPC+ Practice Site. See Figure 7 for an example of practice site-level reporting.

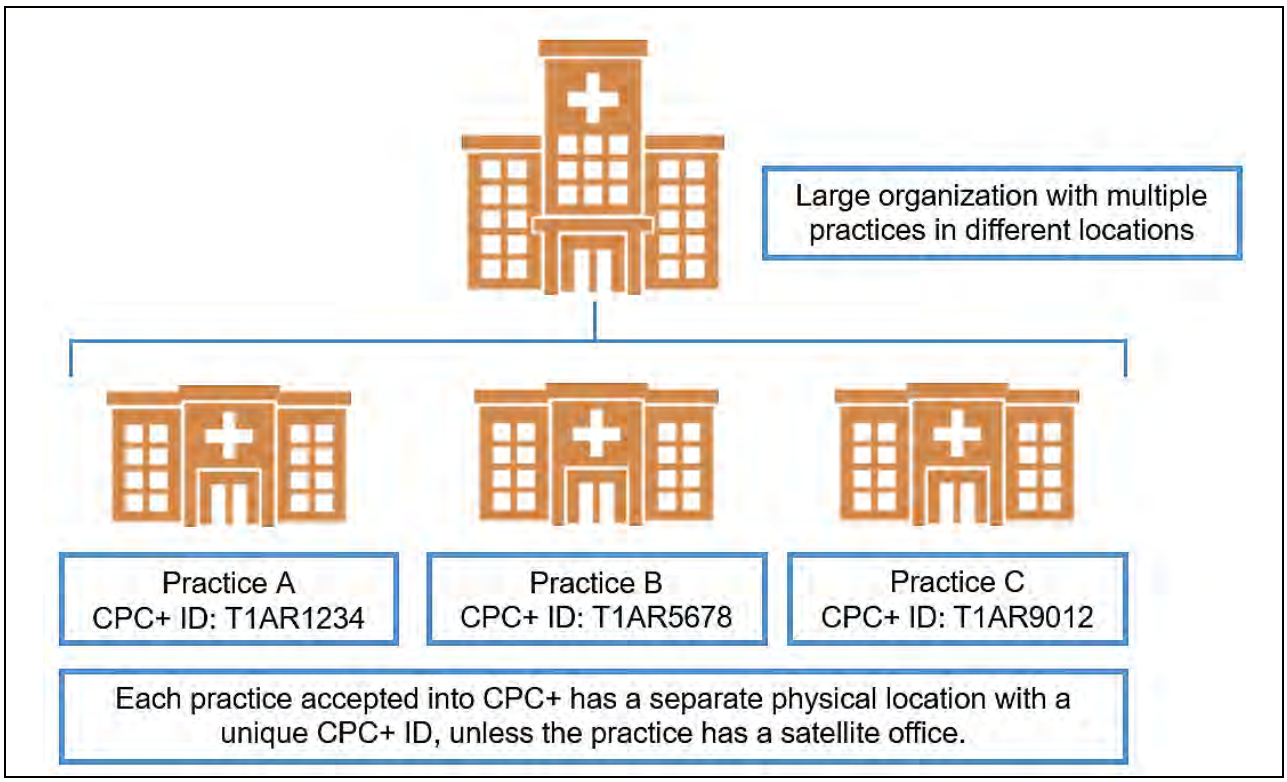


Figure 7: Practice Site-Level Reporting

In addition to CEHRT and certified health IT, CPC+ practices may also use other health IT vendors to help them with care delivery reporting or practice management. Any health IT vendor that your practice uses to meet the CPC+ program requirements should be listed in the CPC+ Practice Portal. Follow directions in Appendix G to ensure that it reflects all health IT vendors used for the CPC+ program.

You should obtain an eCQM report from your health IT vendor. The report may be one or more pages and you may need to generate information from different areas of your EHR or health IT to provide all the information required. We also recommend you periodically pull test reports from your CEHRT and certified health IT to ensure that your practice's calculated performance rates are correct.

Figure 8 is a report checklist to help you select and document your progress for each quarter of eCQM tracking.

How to keep the quality component of your PBIP and qualify for the utilization component for 2018 Program Year

Your performance on electronic clinical quality measures (eCQMs) will determine the largest share of your CPC+ Performance-Based Incentive Payment (PBIP). To qualify for the PBIP, your practice must report 9 of 19 eCQMs in the CPC+ eCQM Measurement Set.

1 Select 9 of 19 eCQMs in the CPC+ eCQM Measurement Set

(Must include the first two measures: 236 and 001)

2 Track Your Progress

If you reach this benchmark → 30th percentile / 70th percentile

55.40% / 71.01%

Then you keep this percent of the PBIP allotted to this measure → 100%

3 Record Your Actual Quarterly Progress

		Measure Title *(MIPS ID)*	30th percentile	70th percentile	Q1	Q2	Q3	Q4
☐	CMS165v6	Controlling High Blood Pressure *(236)*	55.40%	71.01%				
☐	CMS122v6	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) *(001)*[a]	35.90%	9.09%				
☐	CMS125v6	Breast Cancer Screening *(112)*	22.22%	55.26%				
☐	CMS130v6	Colorectal Cancer Screening *(113)*	15.98%	56.20%				
☐	CMS124v6	Cervical Cancer Screening *(309)*	15.09%	45.00%				
☐	CMS131v6	Diabetes: Eye Exam *(117)*	80.69%	98.58%				
☐	CMS134v6	Diabetes: Medical Attention for Nephropathy *(119)*	72.92%	89.96%				
☐	CMS50v6	Closing the Referral Loop: Receipt of Specialist Report *(374)*	6.25%	36.96%				
☐	CMS156v5	Use of High-Risk Medications in the Elderly *(238)*[a]	21.22%	0.90%				
☐	CMS2v7	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan *(134)*	2.94%	30.30%				
☐	CMS160v6	Depression Utilization of PHQ-9 Tool *(371)*	1.96%	12.24%				
☐	CMS149v6	Dementia: Cognitive Assessment *(281)*	17.57%	88.14%				
☐	CMS138v6	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention *(226)*	81.60%	94.68%				
☐	CMS137v6	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment *(305)*	0.95%	5.13%				
☐	CMS139v6	Falls: Screening for Future Fall Risk *(318)*	17.93%	81.05%				
☐	CMS147v7	Preventive Care and Screening: Influenza Immunization *(110)*	18.58%	47.87%				
☐	CMS127v6	Pneumonia Vaccination Status for Older Adults *(111)*	23.26%	63.61%				
☐	CMS164v6	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet *(204)*	63.77%	82.00%				
☐	CMS347v1	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease *(438)*	65.41%	77.22%				

[a] This measure is reverse-scored.

The amount of PBIP your practice can keep increases as you achieve more of the quality and reporting benchmarks listed below.

	Payment Eligibility		Quality		Utilization	
	Not eligible to keep your PBIP	Eligible to keep at least some PBIP	Partial Payment	Full Payment	Partial Payment	Full Payment
You do not report at least 9 eCQMs or you do not receive a CAHPS score	✗					
You report at least 9 eCQMs and receive a CAHPS score (10 quality measures total)		✗				
You achieve ≥ 30th percentile on 1–5 quality measures[a]		✗	✗			
You achieve ≥ 30th percentile on 6–10 quality measures, but < 6 quality measures reach 70th percentile		✗	✗		✗ if you achieve 50th percentile on ≥ 1 utilization measures	✗ if you achieve 80th percentile on 2 utilization measures
You achieve ≥ 30th percentile on all 10 quality measures, with ≥ 6 quality measures ≥ 70th percentile		✗		✗	✗ if you achieve 50th percentile on ≥ 1 utilization measures	✗ if you achieve 80th percentile on 2 utilization measures

[a] Quality measures include the 9 electronic Clinical Quality Measures (eCQMs) and the 1 CAHPS Summary Score.

Figure 8: eCQM Report Checklist

CPC+ participants have two separate options for reporting eCQM data:

1. **Attestation of eCQM results.** If you choose to report your eCQM data through attestation, you will use the CPC+ Practice Portal to enter (attest to) the quality measure data results. Instructions on how to submit your eCQMs will be released each year prior to the reporting period. For those practices reporting eCQM data in 2017, the following resources are available: CPC+ 2017 eCQM Reporting Guide and Submitting Your 2017 eCQM Data to CMS On-Demand Webinar.

2. **Quality Reporting Document Architecture (QRDA) III electronic submission of eCQM results.** The electronic file format for submitting eCQM results directly from your EHR is called "QRDA III." CPC+ practices can either submit an electronic file directly from their EHR or have a third-party intermediary submit an electronic file on their behalf. Guidance on how to submit your eCQM data through QRDA III will be released each year prior to the reporting period.

As a CPC+ participant, you should retain a hard copy of the eCQM report with the annual results you submit to CMS for 10 years in case of a potential eCQM audit. A sample of CPC+ practices will undergo an eCQM audit annually after each eCQM reporting period.

Figure 9 displays the timeline of key quality-related events for each year's quality measurement and reporting period. The details in the paragraphs below Figure 9 walk you through this timeline.

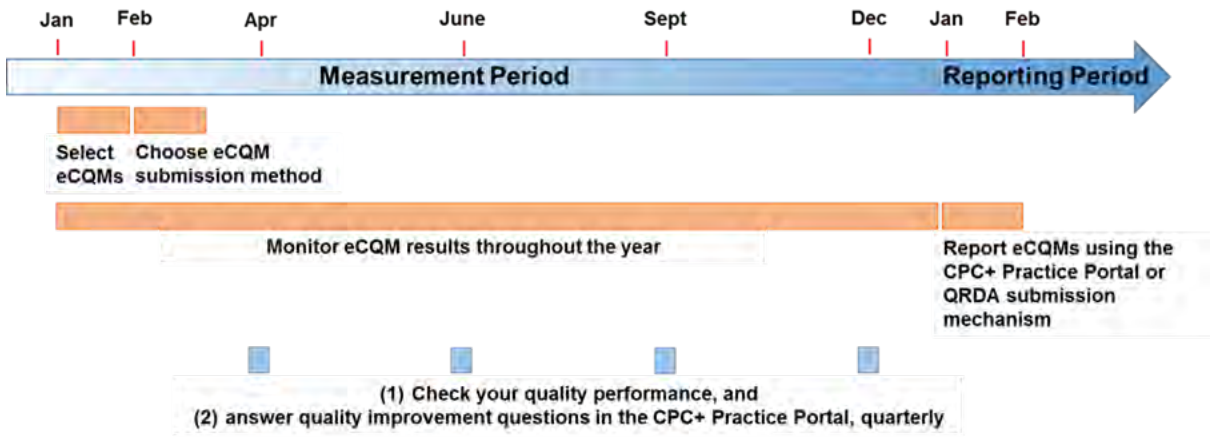


Figure 9: Timeline of Key Quality-Related Events for the 2018 Performance Measurement and Submission Periods

For more specific guidance on how to complete annual quality reporting, please access the following resources:

- CPC+ 2017 eCQM Reporting Guide
- 2018 eCQM Measure Set
- 2018 CPC+ Health IT Requirements
- *2018 eCQM and Health IT Review* webinar
- 2018 eCQM Highlights and Changes
- 2018 eCQM benchmarks
- Health IT policies and guidelines
- eCQMs Introduction (Module 1) on-demand webinar
- eCQM Requirements (Module 2) on-demand webinar
- eCQM Tracking Your Practices eCQM Performance (Module 3) on-demand webinar
- eCQM Reporting (Module 4) on-demand webinar
- *Submitting Your 2017 eCQM Data to CMS* webinar

CPC+ Alignment with Other CMS Quality Programs

Quality Payment Program and CPC+

The Quality Payment Program (QPP), established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), is a quality payment incentive program for physicians and other eligible clinicians, which rewards value and outcomes in one of two ways: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). The goal is to support patients and clinicians in making their own decisions about health care using data driven insights, increasingly aligned and meaningful quality measures, and innovative technology. To implement this vision, the QPP emphasizes high-value care and patient outcomes while minimizing burden on eligible clinicians.

In November 2017, updates to the QPP were released in the final rule (with comment period) making payment and policy changes effective January 1, 2018. You can find more information on the CY 2018 Updates to the QPP at https://qpp.cms.gov.

Practitioners who participate in CPC+ are either a Qualifying APM Participant (QP) or Partial QP. QPs are exempt from reporting to MIPS. The QP performance period is January 1 through August 31 each year, with QP determinations made using data from March 31 through June 30, and through the last day of the QP performance period (August 31), respectively. For dual participants in CPC+ and the Medicare Shared Savings Program, regardless of your Track in CPC+, your ACO (not your CPC+ practice) is the “APM Entity” that determines how you report, how you are scored, and how you are reimbursed. You can always confirm your practitioners' collective status via the MIPS Participation Status webpage.

You can find more information about CPC+ participants’ interaction with QPP on CPC+ Connect in the recorded webinar and fact sheet.

Additional questions/comments regarding the overlap between QPP and CPC+ should be sent to either the QPP Help Desk (QPP@cms.hhs.gov or 1-866-288-8292) or CPC+ Support (CPCPlus@telligen.com or 1-888-372-3280).

Medicare Shared Savings Program and CPC+

CPC+ primary care practices that are Medicare Shared Savings Program Accountable Care Organizations (ACOs) may also participate in CPC+. CMS identifies these practices as “dual participants.” Key questions and answer for dual participants relevant to quality reporting are listed below and can be found in the Medicare Shared Savings Program Interaction with Comprehensive Primary Care Plus (Program Year 2018).

Here are some frequently asked questions (FAQs) by practices regarding dual participation in the Shared Savings Program and CPC+:

Do dual participants have to report quality measures required by the Shared Savings Program? Yes, the ACO in which the dual participant is participating must meet all quality reporting requirements of the Shared Savings Program.

Are dual participants' Medicare fee-for-service (FFS) patients subject to the CAHPS for ACOs survey required by the Shared Savings Program? Yes, CMS may ask Medicare beneficiaries attributed to ACOs that include dual participants through the Shared Savings Program to participate in the annual CAHPS for ACOs survey that is part of the Shared Savings Program quality standard.

CPC+ will also conduct CAHPS surveys on a sample of all dual participants' patients (associated with Medicare and other payers). CPC+ and the Shared Savings Program will work together to prevent FFS Medicare beneficiaries from receiving both the CAHPS for ACOs and the CPC+ CAHPS surveys, thereby limiting the survey burden of any individual beneficiary.

Do dual participants have to report eCQMs to CPC+? Yes, dual participants must meet all quality reporting requirements of CPC+, including reporting 9 of the 14 eCQMs in the 2017 Measurement Period and 9 of the 19 eCQMs in the CPC+ eCQM measure set for the 2018 Measurement Period.

Are dual participants in Shared Savings Program Track 1 ACOs excluded from MIPS reporting? No, dual participants in Track 1 ACOs are subject to MIPS and will be assessed under the MIPS APM scoring standard. For the 2018 Measurement Period, the requirements of the MIPS APM scoring standard for eligible clinicians in Track 1 ACOs are as shown in Table 17.[61]

Table 17: Reporting Requirement and Performance Score

	Reporting Requirement	Performance Score	Weight
Quality	Medicare Shared Savings Program ACOs submit quality measures to the CMS Web Interface on behalf of their participating MIPS-eligible clinicians.	The MIPS quality performance category requirements and benchmarks will be used to score quality at the ACO level.	50%
Cost	MIPS-eligible clinicians will not be assessed on cost.	N/A	0%

[61] The Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, Table 11—APM Scoring Standard for the Shared Savings Program—2017 Performance Period for the 2019 Payment Adjustment. Retrieved from https://www.federalregister.gov/documents/2016/11/04/2016-25240/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm

	Reporting Requirement	Performance Score	Weight
Improvement Activities	ACOs only need to report if the CMS-assigned improvement activities scores are below the maximum improvement activities score.	CMS will assign the same improvement activities score to each APM Entity group based on the activities required of participants in the Shared Savings Program. The minimum score is one-half of the total possible points. If the assigned score does not represent the maximum improvement activities score, ACOs will have the opportunity to report additional improvement activities to add points to the APM Entity group score	20%
Advancing Care Information	All ACO participant TINs in the ACO submit under this category according to the MIPS group reporting requirements.	CMS will aggregate all of the ACO participant TIN scores as a weighted average based on the number of MIPS eligible clinicians in each TIN to yield one APM Entity group score.	30%

Eligible clinicians participating in the ACO will receive the same MIPS score, which will lead to either a positive, neutral, or negative payment adjustment in 2020. Because the 2019 Measurement Period may not follow the same APM scoring standards, dual participant practices should review future communications from CMS as well as monitor the QPP website for changes to these standards.

Are dual participants in the Shared Savings Program Track 2 or 3 ACOs excluded from MIPS? The Shared Savings Program Tracks 2 and 3 are Advanced APMs and eligible clinicians in dual participant practices may receive the 5 percent lump sum bonus and a MIPS exemption if their ACO meets the required standards of the QPP.

Is a dual participant eligible to receive shared savings payments under the Shared Savings Program? Dual participants may be eligible for shared savings payments based on the ACO's performance as assessed by the Shared Savings Program, and the terms and conditions of the ACO participant agreement the dual participant's practice signed with the ACO.

Does a dual participant receive the CPC+ PBIP? No, but instead of receiving the CPC+ PBIP, dual participants are included in their ACO's shared savings/loss arrangement. Dual participants will receive CPC+ care management fees and, if in CPC+ Track 2, will receive Comprehensive Primary Care Payments. Both of these payments will be included in their ACO's expenditure calculation.

Additional questions/comments regarding the overlap between the Medicare Shared Savings Program and CPC+ should be sent to CPC+ Support (CPCPlus@telligen.com or 1-888-372-3280).

Useful Resources

Table 18 provides a list of useful resources with links and descriptions. These resources will help your practice succeed in the quality measurement and reporting aspects of CPC+.

Table 18: Quality Measurement Reporting Resources

Resource	Description
Agency for Healthcare Research and Quality – Selecting Quality Measures	This website will guide you in your selection of 9 out of the 19 eCQMs for CPC+ with tools like a side-by-side comparison of two measures.
CAHPS Clinician and Group Survey Measures	This site provides you a list of the CAHPS Clinician and Group Survey Measures.
The eCQI Resource Center	This website is your one-stop shop for the most current electronic clinical quality improvement (eCQI) efforts, including eCQM improvement resources.
The CMS Quality Strategy Site	CMS provides an overview of the CMS Quality Strategy, as well as a plethora of resources to help you achieve your quality goals.
eMeasures Blueprint	This document provides a deep dive into CMS measure development and conceptualization that will provide you meaning behind the measures.
National Quality Forum – ABCs of Measurement	The NQF provides measures that have undergone rigorous scientific and evidence-based review, input from patients and their families, and the perspectives of people throughout the healthcare industry.
Joint Commission Pioneers in Quality	This resource is a Joint Commission program to assist you in your journey towards eCQM adoption, which is a vital aspect of CPC+ implementation.
Developing a CAHPS® Clinician & Group Survey to Measure the Medical Home	The Patient-Centered Medical Home (PCMH) CAPHS survey is currently under development. This document describes what the PCMH survey consists of, as well as links to other related resources.
Health IT-Enabled Quality Measurement Strategic Implementation Guide	This guide provides you with a framework for multi-stakeholder engagement, 10 key activities, and a series of tools states can use to assess readiness, technical decisions, and tactics to set up a health IT-enabled quality measurement system.
JIRA CQM Feedback System	JIRA provides a collaboration platform for stakeholders to submit issues with eCQM implementation and tools and receive feedback. If you have technical questions, please use JIRA to ask questions and report issues rather than submitting email, telephone, or paper issues.
Value Set Authority Center (VSAC)	This site provides you with downloadable access to all official versions of vocabulary value sets included in the eCQMs (a link to the VSAC is also available on the eCQI Resource Center).

Section IV: Payment and Composition Policies

Introduction

This section guides you through key CPC+ program policies, including those related to CPC+ payments and composition. This information will be critical as you implement CPC+ at your practice. Included are links to many resources such a templates, step-by-step instructions, and webinars.

CPC+ Payment Policies

CPC+ offers three payment elements to support and incentivize practices to better manage patients' health and to provide higher quality of care. The payment designs differ for Track 1 and Track 2 CPC+ practices. The three payment elements are the same for 2017 starters and 2018 starters including:

1. **Care management fee (CMF).** CMF is a non-visit-based fee that will be paid to both Track 1 and Track 2 practices quarterly. The amount of CMF is determined by: (1) the number of beneficiaries attributed to a given practice per month, (2) the case mix of the attributed beneficiary population, and (3) the CPC+ track to which the practice belongs. Practices serving a greater number of high-risk beneficiaries are expected to provide more intensive care management and practice support. Thus, the CMF amount is risk adjusted to reflect the attributed population's risk level. Track 2 practices will receive a higher CMF **for patients with complex needs.**

2. **Performance-based incentive payment (PBIP).** For Standard Participants (not Dual Participants), CMS will prospectively pay the full amount of PBIP at the beginning of each program year. After each program year ends, CPC+ will retrospectively reconcile the amount of PBIP that a practice earned based on how well the practice performed on patient experience of care measures, clinical quality measures, and utilization measures that drive total cost of care. Practices will either keep their entire PBIP, repay a portion, or repay all of it. The full amount of PBIP that is prospectively paid is determined by: (1) the number of beneficiaries attributed to a given practice per month and (2) the CPC+ track to which the practice belongs. The PBIP amount earned in a program year is determined by: (1) the number of beneficiaries attributed to a given practice per month, (2) the CPC+ track to which the practice belongs, and (3) the practice's performance on the measures listed above. PBIP is calculated separately for each of the quality component (including patient experience of care) and utilization components. More information on the PBIP quality measures is in Section III.

3. **Payment under the Medicare Physician Fee Schedule.** Track 1 practices will continue to bill and receive payment from Medicare FFS as usual. Track 2 practices will receive a hybrid payment, meaning they will be prospectively paid Comprehensive Primary Care

Payments (CPCPs) with reduced FFS payments. The CPCP is a lump sum quarterly payment based on historical FFS payment amounts for selected primary care services. Track 2 practices will continue to bill as usual, and the FFS payment amount will be reduced proportionally to offset the CPCP. The CPCP amounts will be larger than the historical FFS payment amounts they are intended to replace, as Track 2 practices are expected to increase the breadth and depth of services they offer.

Collectively, CPC+ payments from Medicare and commercial payer partners are intended to support practice-wide transformation for all patients at the practice, regardless of insurance type. As such, CPC+ Medicare attribution is the mechanism for determining the approximate size and acuity of the Medicare FFS population receiving regular continuous care within the CPC+ practice. Beneficiary attribution is conducted on a quarterly basis and used to determine payment amounts for CMF, PBIP, and CPCP with FFS reduction (i.e., hybrid payment).

The attribution process uses multiple steps to assign beneficiaries to practices. Using Medicare administrative data, we first identify CMS beneficiaries eligible for attribution to CPC+ practices. We then examine the most recent 24-month historical (or "lookback") period in Medicare claims data to determine which practice to attribute eligible beneficiaries to. Beneficiary attribution to a practice is generally determined first by Chronic Care Management (CCM)-related services, then by Annual Wellness Visits and Welcome to Medicare Visits, and last by the plurality of eligible primary care visits within the 24-month lookback period. CMS is also exploring the addition of voluntary alignment by beneficiaries via MyMedicare.gov to the attribution methodology.

On December 1, 2017, CMS released an updated CPC+ Payment Methodologies paper. The updated paper includes clarifications to the PBIP requirements, the risk tiers for the care management fees, and updated quality measure benchmarks for the PBIP. For this and more information on payment methodologies and policies, access the updated CPC+ Payment Methodologies paper here. The payment policy FAQ provides a comprehensive list of answers to frequently asked questions about use of CPC+ funds. You can access this document here.

Practice Composition Policy

We know that over the course of CPC+, the practitioners and staff in your practice may change, and your practice may change ownership, location, and billing information. As part of the Participation Agreement, each practice has agreed to keep its practice information, and practitioner and staff rosters up-to-date. Current and accurate information will assure correct payment, assist CMS in monitoring your practice's performance, and ensure your practice receives accurate and timely program information.

You can quickly and easily submit some changes through the CPC+ Practice Portal. Other changes, in particular those with impact on your CPC+ payments, are more complex and require approval after you submit the change in the CPC+ Practice Portal. Above all, it is

imperative that your practice be mindful of notifying CMS immediately of any changes to staffing, ownership, or location.

Composition Change Request Process

Your practice will submit requests to update your practitioner roster, staff roster, Tax ID Number (TIN), and organizational affiliation through the CPC+ Practice Portal. The CPC+ composition team will review each request and respond via the CPC+ Practice Portal. These responses will indicate if additional information is needed, or if the request is approved or rejected. Step-by-step instructions, as well as screen shots for each of these composition changes, are included in Appendix I, Updating Practice Information.

More complex changes in composition, such as practice mergers, acquisitions, and practice splits, require more information and need to be submitted as soon as the practice has any indication of a possible change to CPC+ Support at CPCPlus@telligen.com or 1-888-372-3280.

Practitioner Roster Changes: Practitioner Adds/Withdraws

Your practice may add or withdraw practitioners at any time during CPC+. CMS will only use practitioners who are formally part of your practice's practitioner roster to determine beneficiary attribution and for payments. For CMS to consider practitioners part of your CPC+ practitioner roster, they must:

- Be a physician (MD or DO), Nurse Practitioner (NP), Physician Assistant (PA), or Clinical Nurse Specialist
  - Your practice does not need a physician (MD/DO) on your roster to remain in CPC+, and can have exclusively other practitioner types, such as NPs and PAs.
  - Residents and fellows may participate in CPC+.
  - No minimum number or percentage of hours is required for a practitioner to be included on your rosters.
- Have a primary specialty of internal medicine, general medicine, geriatric medicine, or family medicine (applicable to physicians only)
- Provide predominantly, though not exclusively, primary care services[62] at the CPC+ practice
- Be paid according to the Medicare Physician Fee schedule for routine office visits and submit claims on a Medicare Physician/Supplier claim form[63]
- Pass a CMS-initiated CMS Center for Program Integrity (CPI) screening to ensure that each practitioner is eligible to bill Medicare

[62] Defined as the following Current Procedural Terminology (CPT) codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, and 99355.
[63] CMS 1500, formerly HCFA 1500.

- Practitioners will be permitted to correct administrative reasons for failure to remain in CPC+.

- Be associated with only one CPC+ practitioner roster at a time
  - In the event the practitioner moves from one CPC+ practice to another, both practices must submit the applicable practitioner add or withdraw requests for each site. CPC+ Support will assist in coordination of practitioner assignment in these situations. CMS will not add practitioners to a different CPC+ practice until a withdrawal has been processed from the initial CPC+ practice.
- Plan to be at the practice for more than three months
  - CMS will not add *locum tenens* practitioners covering temporarily for other practitioners in the practice if they are covering for less than three months.
- Not charge beneficiaries concierge fees
  - Practitioners charging concierge fees for patients not attributed to CPC+ must: (1) use a TIN separate from your practice, (2) must keep their funds separate from your practice, and (3) notify CPC+ Support of the concierge services they are offering.
- Not be engaged in any fraudulent or illegal activity

Please refer to Appendix G, Getting CPC+ Practice Portal Access, a step-by-step guide for getting access to the CPC+ Practice Portal.

Changing a Practice Name

Practices may have updates to their name for a variety of reasons. Practice name changes should be reported to CPC+ Support by phone or email, and must be accompanied by a copy of a legal document effecting the name change, authenticated by the appropriate state official (if applicable). Upon processing, CMS will amend your Participation Agreement to reflect the change of your CPC+ practice's name.

Changing a Practice TIN

CMS recognizes that during the course of CPC+, business changes may occur, including changes to your practice TIN. At the beginning of your participation, you will verify that the TIN listed in the CPC+ Practice Portal is correct. If the CPC+ Practice Portal lists an incorrect TIN, or if you have changed your TIN since the submission of the application to CPC+, you must update this information in the CPC+ Practice Portal and submit a TIN Change Confirmation form that is signed by your signatory authority or an individual authorized to legally bind your organization. CPC+ Support will send this form to the practice contact after a TIN change has been requested by the practice in the CPC+ Practice Portal.

In certain circumstances, a TIN change may require additional follow-up. For example, if a TIN is changed due to a change in ownership, the CPC+ Composition team will ask for additional

details. In addition, practices may need to update banking information as the result of a TIN change to ensure CMS deposits CPC+ payments into the appropriate account.

Please refer to Appendix I, Updating Practice Information, for a step-by-step guide for updating your practice TIN in the CPC+ Practice Portal.

Joining the Medicare Shared Savings Program

If your practice intends to join the Shared Savings Program while participating in CPC+, you will need to notify CPC+ Support within 30 days of becoming an Accountable Care Organization (ACO) participant.

Additionally, you will need to notify CPC+ Support when you receive notice of your acceptance/denial in the Medicare Shared Savings Program. If accepted, it is highly recommended for your practice to submit a written statement signed by a representative of the leadership of the Shared Savings Program ACO to CMS. This statement needs to acknowledge that your practice's participation in CPC+ may impact the ACO's total expenditures and, if applicable, acknowledge that any CPC+ payments made to your practice as an ACO will be segregated from all other funds of the ACO and will be used solely by the CPC+ practice.

If your practice plans to join the Medicare Shared Savings Program, please be sure to read the sections of the CPC+ Participation Agreement and comply with all terms relevant to practices participating in both the Shared Savings Program and CPC+.

Withdrawing a Practice

Practices may withdraw from CPC+ at any time. If your practice decides to withdraw, you must take the following actions:

- Notify CPC+ Support of intent to withdraw 30 calendar days in advance.[64]
- Complete the CPC+ practice withdrawal forms provided by CPC+ Support.
- Identify any practitioners who are moving to another CPC+ practice.
- Submit care delivery requirements in the CPC+ Practice Portal for the last quarter of participation.
- Submit partial- or full-year forecasts and financial reports depending on the effective withdrawal date.
- Submit eCQM results if the withdrawal is effective on December 31.
    - Withdrawal prior to the end of the calendar year will result in forfeiture of the PBIP for practices not also enrolled in the Shared Savings Program.

[64] Requests for practice withdrawal in the first quarter of 2017 are exempt from this requirement and should provide notification as soon as the decision to withdraw is made.

- Submit a beneficiary notification letter that notifies your beneficiaries that your practice participation in CPC+ has ended for CMS review and approval. Upon approval, your practice will distribute this notification letter to your beneficiaries.
- Submit to CMS written certification that the applicable CPC+ data have been destroyed.

In some circumstances, CMS may terminate a practice from CPC+ for cause. Termination can occur for a variety of reasons, including a practice's inability or unwillingness to meet the requirements of its Participation Agreement, or a practice's involvement in fraudulent or illegal activity. A practice must still complete the required actions associated with a withdrawal, regardless whether the withdrawal if voluntary or involuntary.

Adding a Practice Site

There are two allowable circumstances for a practice site to add a second location: (1) opening a satellite site or (2) the splitting of a practice site into two practice sites. Table 19 describes the requirements for each circumstance. A satellite practice remains under the same CPC+ Practice ID, while a true practice split will receive a new Practice ID the following calendar year.

Table 19: Allowable Circumstances to Add Another Site to a Practice Site

Topic	Satellite Site[65]	Practice Split
Description	An additional site opened to accommodate a patient panel that is geographically dispersed	A geographic extension of the original practice site as a result of natural growth of the patient panel/volume and physical space limitations at the current practice location
Notice required	60 days	60 days
Notification Method	Contact CPC+ Support	Contact CPC+ Support
Shared Resources	All or a subset of practitioners from the initial CPC+ practice need to work at the satellite location. The practice cannot add new practitioners only to the satellite location. The exception to this is for specialists who do not meet the definition of a CPC+ practitioner. Both sites share the same personnel, management, practitioners, EHR, beneficiaries, and other resources. Note: Each site can have separate administrative staff.	Both sites share the same management, health IT, and EHR, but may have different personnel and practitioners. Some original CPC+ practitioners will need to be at the existing practice location and the new practice for purposes of continuity and likelihood of success. CMS will not approve a new practice site without practitioners with CPC+ experience.

[65] Being in the same medical group or health system does not constitute being a satellite practice.

Topic	Satellite Site[65]	Practice Split
Clinical Requirements	All practitioners at the satellite location must practice at the main CPC+ practice site. Note: CMS may allow specialty practitioners to work only at the satellite site with CMS approval.	Practitioners may work at both practice sites, or only one. If a practitioner was not part of the original practice, practices must submit a practitioner add request.
CPC+ Payments	CMS considers the satellite site part of the CPC+ Practice Site and payments from CPC+ will not be split between the original practice site and satellite location.	CMS will make payments to the new practice per the payment schedule.
Effective date of change	Upon completion of processing request.	The effective date will be the first of the following calendar year (if appropriate notice is given). For the remainder of the program year, the new practice will be treated as a satellite.

Important Information about Practice Splits

- Requests received on or before September 30, 2018 that CMS approves will be effective January 1, 2019.
- Requests received after September 30, 2018 that CMS approves will be effective January 1, 2020.

Practice Mergers and Acquisitions

You have the freedom to make the right decisions for your practice. If your practice merges with another practice, acquires another practice, or is acquired by another practice, your practice should take the steps detailed in Table 20 or Table 21. Table 20 details the steps you need to take and implications for reporting and payment when two CPC+ practices merge that are participating in the same or different tracks. Table 21 details the steps and implications for your CPC+ practice and the new parent owner when an acquisition has occurred. CMS may condition its consent to the CPC+ practice's change in control by requiring the new controlling entity to execute a novation agreement with CMS or requiring the new controlling entity to execute a new Participation Agreement.

Mergers

Table 20: Practice Mergers

Topic	Same Track Mergers	Different Track Mergers
Description	Merger of two CPC+ practices that are in the same track or a merger of an existing CPC+ practice with a non-participating CPC+ practice	A merger where both practices participate in CPC+ but in different tracks
Notice required	60 days	60 days
Notification Method	Contact CPC+ Support	Contact CPC+ Support
Track assignment	The current track assignment will not be changed.	CMS will determine the track for the merged practice sites based on the track of the larger practice, identified by number of participating NPIs. When NPI counts match, the practice track that has the larger number of attributed beneficiaries will be used.
Reporting Timeline	Merged practices will begin to report as one site for the quarterly reporting period in which the merger effective date occurred.	Merged practices will begin to report as one site for the quarterly reporting period in which the merger effective date occurred.
CPC+ Payments	Payment will be consolidated to the one CPC+ practice.	Payment will be consolidated to the one CPC+ practice. If the merged practice is Track 1, the practice will stop receiving CPCP as of the effective date of the change. If the merged practice is Track 2, they will start receiving CPCP as of the effective date of the change.
Effective date of change	The date of the physical move where the two practices share the same physical location.	The date of the physical move where the two practices share the same physical location.

Acquisitions

Table 21: Practice Acquisitions

Topic	New Owner
Description	A CPC+ practice is acquired by a new parent owner
Notice required	60 days
Notification Method	Contact CPC+ Support.
Track assignment	The current track assignment will not be changed.
Reporting Timeline	Reporting requirements and timeline are not impacted.
CPC+ Payments	Banking information is often updated when a practice obtains a new parent owner. The amount of payments will not be affected.
Effective date of change	The day in which the new parent owner legally has ownership of the practice

CMS will contact the new parent owner to orient the organization to the CPC+ model requirements. CMS wants to ensure a smooth transition and increase the likelihood of practice success when new parent organizations acquire existing CPC+ practices.

Additional Practice Changes to Report

As noted in your CPC+ Participation Agreement, you will need to notify CPC+ Support if there are changes in your practice's business ownership structure that makes your practice ineligible for participation in CPC+. These situations include the following:

- Changes that result in your practice no longer providing primary care services
- Designation as a Rural Health Clinic or Federally Qualified Health Center
- Changes that result in participation in a CMS program with a no-overlaps policy with CPC+, such as the Next Generation ACO Model and the Independence at Home Demonstration

Understanding the Impact of Composition Changes

Note: In addition to impacts discussed below, composition changes in CPC+ may also affect QP (Qualifying Participant) status within the Quality Payment Program (QPP). Please consult CPC+ Support and the QPP Help Desk (QPP@cms.hhs.gov or 1-866-288-8292) for discussion of impacts.

Beneficiary Attribution

The CPC+ practice site, along with the practice Tax Identification Number (TIN) or CMS Certification Number (CCN) for Critical Access Hospitals (CAHs), and the National Provider Identifiers (NPIs) for each practitioner at a practice site are used by CMS for beneficiary attribution calculations[66] and the calculation of the care management fee. CMS uses these data to identify Medicare primary care services provided by your CPC+ practice.

Your practice's CPC+ practitioner roster determines the TINs, NPIs, and CPC+ effective dates. Any change made to your practitioner roster may impact the beneficiaries that are attributed to your practice, which may affect your practice's CPC+ payments.

Different types of composition changes have different processing times from when a practice submits the change to the effective date in the CPC+ practitioner roster, as noted in Table 22.

[66] For additional information on beneficiary attribution and CPC+ payment methodologies, please refer to the *CPC+ Payment Methodologies: Beneficiary Attribution, Care Management Fee, Performance-Based Incentive Payment, and Payment under the Medicare Physician Fee Schedule*.

Table 22: Composition Change Impacts: Beneficiary Attribution and Joining the Shared Savings Program

Composition Change Impacts: Beneficiary Attribution	
Practitioner Roster Updates	When CPC+ practitioners leave a practice, their NPIs remain on the CPC+ practitioner roster and marked with a termination date. In this way, CMS will count past visits to those practitioners (i.e., visits during the lookback period) toward the practice when beneficiary attribution is calculated. When practices add CPC+ practitioners, CMS adds their NPIs to the CPC+ practitioner roster and includes them in the next quarter's beneficiary attribution. CMS will use the date the practitioner joined the practice for attribution.
TIN Change	TIN changes are used for beneficiary attribution when the update has been approved. Historical TINs continue to be used in attribution to capture eligible visits in the lookback period. A new TIN will not affect attribution until claims billed under the new TIN are included in the lookback period.
Joining the Medicare Shared Savings Program	Participation in the Shared Savings Program can affect beneficiary attribution. Practices may see an increase.
Practice Withdrawal (voluntary or involuntary)	**CMS will remove the practice from the beneficiary attribution calculations.**
Adding a Practice Site	CMS will add the practice to the first beneficiary attribution calculations for the program year that it became a CPC+ participant.
Practice Mergers and Acquisitions	CMS will add practices that merge to the applicable quarterly beneficiary attribution that aligns with the quarter that the merged practice became eligible. Practice acquisitions do not impact the beneficiary attribution; however, practices need to report TIN changes, which are often part of an acquisition, to have any new TIN included in beneficiary attribution calculations.

Care Management Fee

CMS pays the care management fee (CMF) quarterly, based on a per-beneficiary per-month (PBPM) calculated amount. The number of beneficiaries attributed to a given practice per month, the hierarchical condition category (HCC) scores relative to the other practices, and the CPC+ track to which the practice belongs determine the CMF.

Composition changes affecting the attributed beneficiary calculation will affect the PBPM through changes to the distribution of beneficiaries in each of the risk tiers, as shown in Table 23.

Table 23: Composition Change Impacts: Care Management Fee

Composition Change Impacts: Care Management Fee	
Practitioner Roster Updates	Changes in the NPIs used in attribution may yield a different pool of attributed beneficiaries. A different attributed population may affect the total CMF through changes in the attributed population's case mix. The CMF total amount for each quarter also depends on the number of attributed beneficiaries.
TIN Change	A new TIN will not impact your attribution calculations until claims with dates of service in the lookback period used for beneficiary attribution have been processed.
Joining the Medicare Shared Savings Program	Participation in the Shared Savings Program can affect your care management fee if your attributed population changes.
Practice Withdrawal (voluntary or involuntary)	Depending on the timing of your practice withdrawal effective date, CMS may recoup CMFs paid to your practice. CMS may also recoup any debits identified for past beneficiary attribution cycles.
Adding a Practice Site	The practice will receive its first CMF for the quarter in which it joins CPC+.
Practice Mergers and Acquisitions	Practices that merge will see the impact to their CMF in the quarter in which the merged practice is effective.

Performance-Based Incentive Payment

CMS determines the amount of PBIP by: (1) the number of beneficiaries attributed to a given practice in the first quarter of each year, and (2) the CPC+ track to which your practice belongs. The amount of PBIP your practice is allowed to retain is based on its performance on quality and utilization measures for the year for which the PBIP was paid.[67]

Because CMS pays the PBIP prospectively and then reconciles it at the end of the performance period, composition changes will not significantly affect this payment unless your practice performance on measures is greatly impacted (see Table 24). Additional information on how this payment is impacted is provided in subsequent specific composition changes.

Table 24: Composition Change Impacts: Performance-based Incentive Payment

Composition Change Impacts: Performance-based Incentive Payment	
Practitioner Roster Updates	Practitioner changes will not significantly affect the PBIP reconciliation, unless such changes greatly impact your practice's performance on measures. If a practice has a dramatic increase or decrease in the number of practitioners, the next program year's PBIP will be impacted accordingly. The PBIP also depends on the number of attributed beneficiaries.

[67] For additional information on beneficiary attribution and CPC+ payment methodologies, please refer to the *CPC+ Payment Methodologies: Beneficiary Attribution, Care Management Fee, Performance-Based Incentive Payment, and Payment under the Medicare Physician Fee Schedule*.

Composition Change Impacts: Performance-based Incentive Payment	
TIN Change	TIN changes have no direct impact on the PBIP. However, practices should update banking information, when applicable.
Joining the Medicare Shared Savings Program	Practices that join the Shared Savings Program are not eligible to receive a PBIP.
Practice Withdrawal (voluntary or involuntary)	CMS may recoup the PBIP paid to your practice based on the effective date of your practice's withdrawal.
Adding a Practice Site	The practice will be eligible for PBIP on January 1 of the year that it joins CPC+.
Practice Mergers and Acquisitions	These impacts will be determined by CMS on a case-by-case basis.

Comprehensive Primary Care Payments (Track 2 only)

As shown in Table 25, Track 2 practices will receive a hybrid payment, meaning CMS will prospectively pay them Comprehensive Primary Care Payments (CPCPs) with commensurately reduced FFS payments. The CPCP is a lump sum quarterly payment based on historical Office Visit Evaluation and Management (E&M) FFS payment amounts. Track 2 practices will continue to bill as usual, but CMS will reduce the FFS payment amount to account for the CPCP.

Table 25: Composition Change Impacts: Comprehensive Primary Care Payments

Composition Change Impacts: Comprehensive Primary Care Payments	
Practitioner Roster Updates	Any new practitioners added to the CPC+ practitioner roster will be included in the practice's CPCP calculation for the payment quarter and have its FFS payment reduced by the amount the practice selected for the respective year. Practitioners who withdraw will not carry the reduced FFS amount forward to their new practice location, unless they join a CPC+ practice that is in Track 2. In these cases, the practitioner would have a reduced FFS determined by the CPCP selection made by the new practice.
TIN Change	TIN changes may have an impact on the Medicare FFS claim reduction from the CPCP. Please be aware that the CMS claims system applies the FFS claim reduction when a Track 2 attributed beneficiary has an Office Visit E&M to the TIN/NPI combination on the roster for the quarter. This means that the claim system will apply the FFS claims reduction to a claim submitted by a CPC+ Track 2 practitioner billing an Office Visit E&M for an attributed beneficiary at a Track 1 practice or a non-CPC+ participating practice location sharing the same TIN as Track 2 CPC+ practice. If this will be a concern, a potential solution is for CPC+ Track 2 practices to bill under a separate TIN.
Joining the Medicare Shared Savings Program	Participation in the Shared Savings Program will not affect your CPCPs.
Practice Withdrawal (voluntary or involuntary)	The FFS payment will revert to 100 percent after practices update the withdrawal information, which occurs on a monthly basis. CMS will perform partial reconciliation of the CPCP based on the effective date of the practice withdrawal.

Composition Change Impacts: Comprehensive Primary Care Payments	
Adding a Practice Site	If the practice is in Track 2, it will need to identify their upfront CPCP percentage.
Practice Mergers and Acquisitions	CMS will determine these impacts on a case-by-case basis.

Quality Reporting

Composition changes may affect quality reporting as shown in Table 26. The impact on reporting requirements varies depending on the type of change the practice is making.

Table 26: Composition Change Impacts: Quality Reporting

Composition Change Impacts: Quality Reporting	
Practitioner Roster Updates	Quality reporting is at a practice level; therefore, individual practitioner changes should not impact quality reporting. Practices may need to update their EHR to reflect updated practitioner information to create their practice-level reports.
TIN Change	A TIN does not affect the quality reporting requirements. The new TIN will be included in the practitioner roster, which CMS will communicate to the QPP.
Joining the Shared Savings Program	Practices participating in the Shared Savings Program are still required to complete quality reporting for CPC+.
Practice Withdrawal (voluntary or involuntary)	CPC+ will provide data on participating practitioners to the QPP on a quarterly basis. Once a practice withdraws from CPC+, the practice will need to identify how it plans to report to the QPP.
Adding a Practice Site	New practice sites will need to be able to meet the quality reporting requirements and will report eCQM beginning with the first year of their addition to CPC+.
Practice Mergers and Acquisitions	Practice mergers and acquisitions do not negate the practice's responsibility to fulfill all the eCQM reporting requirements.

Reporting of Care Delivery Requirements

Composition changes may affect reporting of care delivery requirements, as shown in Table 27. The impact on reporting requirements varies, depending on the type of change that practice is making.

Table 27: Composition Change Impacts: Care Delivery Requirements

Composition Change Impacts: Care Delivery Requirements	
Practitioner Updates	Practitioner updates may impact the information captured in the care delivery requirements. Practitioner changes will need to be evaluated for impact on reporting of this data and incorporated to ensure the applicable information is reported in the practice data.
TIN Change	A TIN does not affect the reporting of care delivery requirements

Composition Change Impacts: Care Delivery Requirements	
Joining the Medicare Shared Savings Program	Participation in the Shared Savings Program will not affect reporting of your care delivery requirements.
Practice Withdrawal (voluntary or involuntary)	CMS may require partial submission of care delivery requirements. Upon final submission of all required data, CMS will terminate all user accounts affiliated with the practice. Such accounts include the CPC+ Practice Portal, CPC+ Connect, and any other CPC+ related programs.
Adding a Practice Site	New practice sites will need to begin reporting care delivery requirements at the end of the first quarter in which it is effective as a CPC+ participant.
Practice Mergers and Acquisitions	Practice mergers and acquisitions do not negate the practice's responsibility to meet care delivery requirements.

Distribution List Updates

Composition changes may affect staff access to the CPC+ Practice Portal, CPC+ Connect, and the distribution list for program information. If your composition change requires updates, please submit those changes to CPC+ Support.

Note: Individuals who would like to be on the CPC+ distribution list to receive program information, such as the weekly distribution of the *On The Plus Side* newsletter, need to be on their practice's roster in the CPC+ Practice Portal. This includes being a practice contact, on the practitioner roster or the staff roster.

Access to CPC+ Connect requires an individual to be on the CPC+ distribution list. Details on the steps required for CPC+ Connect access are located in Appendix H, Accessing CPC+ Connect.

When in Doubt—Reach Out

If you have questions regarding how to perform composition changes in the CPC+ Practice Portal or need to report a change that you cannot process in the CPC+ Practice Portal, contact CPC+ Support at CPCPlus@telligen.com or 1-888-372-3280. Please have your CPC+ ID ready and include it in the subject line of your email.

Appendices

Appendix A. Key CPC+ Resources

Table 28 summarizes key resources available to practices, some of which are included in this Guide.

Table 28: CPC+ Key Resources

Resource	Description
CPC+ Change Package	The CPC+ Change Package, distributed by CMS in January 2018, provides a summary of key drivers, change concepts, and change tactics that contribute to the model's overall aims of more patient centered, high-quality, and cost-effective care. This resource includes a diverse set of ideas that can be helpful in guiding care delivery work in practices.
CPC+ Payment Methodologies	This document, originally released by CMS in December 2017, explains the CPC+ payment methodology.
CPC+ Electronic Clinical Quality Measure (eCQM) Fact Sheet	This fact sheet, distributed by CMS in March 2017, reviews what eCQMs are and how they work in the context of CPC+.
Care Delivery Reporting Guide	This document guides practices through 2018 CPC+ care delivery reporting. Practices should use this guide to prepare for reporting in each quarter, and to identify what information they will need to collect and track. *Note*: *All components of the Care Delivery Reporting Guide are now included in Section II of this Guide.*
Accessing CPC+ Connect	This quick guide provides instructions on how to log into CPC+ Connect, reset your password, and request access for new users. *Note: For more information about how to access CPC+ Connect, please see Appendix H of this Guide.*
Learning and Collaboration Opportunities	This resource outlines upcoming regional and national learning events, including National Webinars, Action Groups, Affinity Groups, Practices In Action (PIAs), and Regional Events in 2018. *Note: The Learning and Collaboration Opportunities are updated monthly, so please check CPC+ Connect for the most recent version.*
Frequently Asked Questions (FAQs)	The FAQs are a compilation of questions and answers addressing key change concepts and tactics of the CPC+ model and related inquiries about payment. Note: The **CPC+ Connect Knowledge** tab also has FAQs that are searchable by key word.
On The Plus Side weekly newsletter	*On The Plus Side* is a weekly newsletter emailed to all practices that includes CPC+ program updates, links to resources, answers to FAQs, and notes upcoming CPC+ events. *Note: Please check CPC+ Connect and search on "newsletter" for the most recent version.*
CPC+ Practice Portal	The CPC+ Practice Portal is your source of current practice information: demographics, practitioner and staff rosters, TINs, organizational affiliation, and health IT vendor information

Appendix B. Useful Tools and Resources

CPC+ has provided tools and resources that your practice can reference for more details on change tactics you choose to adopt, and related evidence-based documentation.[68] As referenced below, we categorized resources to help you easily identify the resource types.

	Templates include documents that practices can modify for their use. Templates include policies, letters to patients, care agreements, confidentiality agreements, and training modules.
	Spotlight examples from CPC+ and CPC Classic practices describing how they implemented a change concept or tactic.
	Movie shorts (most of which are five minutes or less in length) and **recorded webinars** describe a change concept or tactic. Many include interviews with subject matter experts and/or practice representatives who have implemented a change.
	Guidelines, toolkits, and/or checklists provide practices a detailed, step-by-step process for how to implement or test a change concept or tactic.

Function 1: Access and Continuity Resources

Type	Title	Description
	The Safety Net Medical Home Initiative Empanelment Implementation Guide	This implementation guide is a step-by-step tool that provides key steps to successful empanelment. It describes the approach used in the Safety Net Medical Home initiative. You can find more information on tools and webinars on the Safety Net Medical Home webpage.
	Access & Continuity Video: 24/7 Access	In this short CPC+ on-demand video focused on Access and Continuity, you will hear Beth King, the Quality Improvement Coordinator for Associates in Family Medicine, P.C., talk about how her practice addresses the change tactic of providing 24/7 access to a practitioner with real-time access to the EHR.
	IHI Third Next Available Appointment	This IHI webpage provides guidelines on the use and collection process for the "third next available appointment" measure of access.
	IHI: Measure and Understand Supply and Demand	This webpage provides guidelines on measuring demand for all services, measuring supply for all practitioners and staff, and comparing supply and demand to ensure patients receive timely access to care.

[68] You must have an active CPC+ Connect account to access these spotlights. See Appendix H of this Guide for more information on other features of the CPC+ Connect website and a self-registration link.

Type	Title	Description
	Putting Group Visits into Practice	This is an implementation guide for practitioners who want to utilize group visits to support their patients with chronic conditions. It outlines challenges, benefits for group visits, and a step-by-step guide for implementation.
	CPC Classic Spotlight 59: Home Visits Help Brittle and High-Risk Patients Stay in the Continuum of Care	This CPC Classic spotlight highlights how Providence Medical Group offers home visits from a Nurse Practitioner to increase support and expand access for patients whose struggles to come to the office could compromise their health. Providence Medical Group refreshed an old idea to support timely continuity of care and patient engagement for high-risk patients.
	CPC Classic Spotlight 85: Expanding Access to Care through E-visit Technology	This spotlight highlights how the St. Elizabeth Physicians care team decided to offer patients the option of virtual treatment for non-urgent medical issues.

Function 2: Care Management Resources

Type	Title	Description
	Risk-Stratified Care Management and Coordination Tool	This AAFP tool provides a systematic process to developing a risk stratification model using available data.
	Risk Stratification Learning and Action Summary	This CPC+ Learning and Action Summary pulls together the guidance and resources shared during various learning events and organizes content, so that you can easily reference materials as you risk stratify your patients and implement longitudinal care management in your practice.
	CPC+ Spotlight 1: Longitudinal Care Management	This practice spotlight features the Mercy Family Medicine practice. In this feature, Mercy shares its challenges and successes in longitudinal care management of its most complex patients and how its success is rooted in its risk stratification tool.
	CPC+ Spotlight 2: Episodic Care Management	This CPC+ spotlight is centered around episodic care management focused on high-risk patients. It examines some of the work being done by Foresight Family Physicians, based in Grand Junction, Colorado.
	CPC+ Spotlight 3: The Effect of Timely Communication and Home Visits on Improving Readmission Rates	This CPC+ practice spotlight focuses on timely communication and home visits after hospitalizations to improve readmission rates. It follows work done by Maron & Rodrigues Medical group in Florham Park, New Jersey.

Type	Title	Description
	CPC+ Episodic Care Management and Care Coordination Learning and Action Summary	This CPC+ Learning and Action Summary pulls together the guidance and resources shared during various learning events and organizes content, so that you can easily reference materials as you implement episodic care management and care coordination with hospitals in your practice.
	Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation	This toolkit provides a step-by-step guide to improving the medication reconciliation process. It will help your care team evaluate the effectiveness of your medication reconciliation process, as well as identify and respond to any gaps. It promotes a successful approach to medication management and reconciliation that emphasizes standardization of the medication reconciliation process.
	CPC Classic Spotlight 36: Look to CPC Change Package for Strategies as You Expand Your Comprehensive Primary Care Services	This CPC Classic spotlight details how Andaraj Subramanium, MD, shaped his practice's care management capability from scratch. Dr. Andy chose to apply intensive care management to patients with a high-risk score who had also been diagnosed with COPD. He hired and trained a care manager who would call patients within 48 hours of discharge or treatment to effectively close gaps for all patients.
	CPC Classic Spotlight 54: Use Your ED and Hospitalization Follow-Up Data for New Insight on When, How and Why Patients Use Urgent and Emergency Care	This CPC Classic spotlight describes how Latham Medical Group gathers more than 10 data points around a patient's acute care episodes and uses the data to tailor follow-up calls, guide care management, and finetune quality improvement efforts.

Function 3: Comprehensiveness and Coordination Resources

Type	Title	Description
	The Geriatric Assessment	The geriatric assessment is a multidimensional, multidisciplinary assessment designed to evaluate an older person's functional ability, physical health, cognition and mental health, and socio-environmental circumstances.
	CPC+ Spotlight 5: A Successful Implementation of the Primary Care Behaviorist Model	This spotlight focuses on Grants Pass Clinic in Oregon, which successfully implemented the Primary Care Behaviorist model.
	CPC+ Spotlight 7: Implementing Behavioral Health Integration: Care Management Model	This spotlight features the successful behavioral health integration process at Billings Clinic West, which shared its care team's experience and crucial steps to integrating behavioral health, including screening, self-management, stepped care, and medication management.
	Behavioral Health Integration Care Management Model Worksheet	This worksheet helps you integrate behavioral health services into your practice through the CPC+ Care Management Model.
	Behavioral Health Integration (BHI) Worksheet Primary Care Behaviorist Model	This worksheet is for patients living with conditions of mental illness. It breaks down into sub-categories that help patients with mental illness.
	Characteristics of the Care Management for Patients with Mental Illness and the Primary Care Behaviorist Models	The tables in this document describe typical implementation for the two CPC+ foundational strategies: Care Management for Patients with Mental Illness and the Primary Care Behaviorist model. Note that the guidance in these tables does not reflect the only way practices could implement these strategies.
	CPC Classic Practice Spotlight 77: Latham Medical Group BHI	Learn how Latham Medical Group, a CPC+ practice, found the right practitioners, located helpful resources to support transformation work, refined workflows, and measured effectiveness to fully integrate behavioral health (BH) services.
	Behavioral Health Integration (BHI) Care Management Learning and Action Summary	This CPC+ Learning and Action Summary pulls together the guidance and resources shared during various learning events and organizes content, so that you can easily reference materials as you implement care management for patients with mental health and/or substance use conditions in your practice.
	A Guidebook of Professional Practices for Behavioral Health and Primary Care	This AHRQ-funded guidebook was developed to assist the field of primary care and behavioral health in identifying professional practices for developing a workforce for integrated care.
	The Administrative Readiness Tool (ART)	The ART is a self-assessment tool designed to help practices assess and improve the core administrative processes needed most to support primary and behavioral health care integration.

Type	Title	Description
	Integrating Comprehensive Medication Management to Optimize Patient Outcomes	The goal of this resource guide, developed by the Patient-Centered Primary Care Collaborative Medication Management Task Force, is to provide information that facilitates the appropriate use of medications to control illness and promote health, which are critical elements to the Patient-Centered Medical Home's success.
	Medication Management	This Primary Care Team website provides guidance on how practices can help patients overcome the challenges of multiple prescriptions through medication management that assesses medication use and adherence in a non-judgmental way.
	AMA STEPS Forward: Module on Project ECHO	The American Medical Association's STEPS Forward Module on Project ECHO (Extension for Community Healthcare Outcomes) provides numerous tools and resources for primary care practices to establish access to a wide variety of medical and behavioral health specialists via structured telemedicine interactions.
	Primary Care—Specialist Physician Collaborative Guidelines	This document provides an example of a care coordination agreement from Colorado. This physician compact has been developed for general distribution with the support of the Colorado Systems of Care/Patient Centered Medical Home Initiative, funded by the Colorado Health Foundation.
	CPC Classic Spotlight 35: Timely ED and Admissions Follow-Up Still Closes Gaps Even When Patient Mix Changes	This spotlight explores how the CPC+ practice First Street Family Health of Salida, Colorado, ensured timely follow-up and held emergency department (ED) visits steady, despite a dramatic increase in Medicaid patients.
	CPC Classic Spotlight 19: Forming Successful Care Coordination Agreements with a High-Volume Specialist and a Behavioral Health Practitioner	This spotlight explores the steps that Mayfair Internal Medicine, a CPC+ practice, took to establish care coordination agreements with a high-volume specialist and behavioral health practitioner to create a medical neighborhood. This resource will foster creative thinking regarding potential collaborative care agreements, and how to monitor and continually improve the relationship within that agreement.
	Health Leads Screening Toolkit	This Social Needs Screening Toolkit shares the latest research on how to develop an effective social need screening tool and how to screen patients for social needs. The toolkit also provides list of other useful screening tools.
	PRAPARE Toolkit, Chapter 9: Respond to Social Determinants Data with Interventions	This chapter of the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) Toolkit provides practices with guidance and examples on ways to address or ameliorate risks for social determinants of health.

Type	Title	Description
	We-Care Screening Tool	This document is a parent-completed screening tool that focuses on well child visits, evaluation, community resources, advocacy, referral, and ED utilization.
	HealthBegins Screening Tool	This tool provides practices with a way to screen patient risk and social needs.
	CPC+ Behavioral Health Integration Menu of Options	To meet the needs of your patients with common and complex behavioral health needs, your work in CPC+ will follow a menu of options with two foundational strategies for behavioral health integration within your practice: Care Management for Mental Illness and the Primary Care Behaviorist model.
	Advancing Integrated Mental Health Solutions (AIMS Center)	This webpage offers an implementation guide and other resources for collaborative care. It provides an approach that uses care management and a "stepped care" approach to enhance behavioral health services. The approach is based primarily on the IMPACT trial. The AIMS Center also offers care manager training.
	SBIRT: Screening, Brief Intervention, and Referral to Treatment	SBIRT is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. This site introduces SBIRT resources, guides, and webinars.
	Systems of Care/PCMH Initiative Compact Facilitation Guide	This guide provides tools to support practice changes to implement care coordination guidelines within their medical neighborhood by developing tools, key questions, and other resources that aid in collaborative care agreement adoption.

Function 4: Patient and Caregiver Engagement Resources

Type	Title	Description
	National Partnership for Women and Families. Key Steps for Creating Patient and Families Advisory Councils in CPC Practices	This how-to document developed by the National Partnership for Women and Families for CPC+ practices outlines detailed steps for creating a PFAC, including roles and responsibilities for patient advisors, interview questions for potential advisors, and a health care glossary for patients.
	CPC Classic Spotlight 64: Toolkit for End-of-Life Care Helps Care Teams with Effective Conversations	At the request of physicians seeking help with end-of-life planning and conversations, CPC+ practice Hunterdon Healthcare Partners of New Jersey created "Care Planning for Serious Illness," a toolkit for use across its system in both hospital and clinic settings. As described in this spotlight, Hunterdon tapped internal resources—including its patients and families—to build a comprehensive set of resources and tools that better prepare physicians and care teams to help patients with advance care planning.

Type	Title	Description
	CPC+ Patient and Family Advisory Council (PFAC) Learning and Action Summary	This CPC+ Learning and Action Summary pulls together the guidance and resources shared during various learning events and organizes content, so that you can easily reference materials as you establish PFACs and incorporate PFAC feedback in your practice.
	Patient Advisor Application (pg. 30–33)	Pages 30–33 of this document describe a template application from IPFCC that practices can use to think through questions they might ask potential patient advisors.
	CPC+ Spotlight 4: Encouraging PFAC Engagement to Improve Care Delivery	Learn how Family Medical Group Northeast successfully planned for and conducted 17 PFAC sessions. This spotlight describes three effective tactics the practice has used to recruit PFAC participants and the positive impact its PFAC has had on care delivery.
	CPC Classic Spotlight 51: Developing a Highly Effective PFAC over Time: How Structure and Transparency Foster Useful and Actionable Feedback	This CPC Classic spotlight describes the Batesville Family Practice Clinic implementation of its PFAC. Read this spotlight to learn about how Batesville Family Practice Clinic revised its recruitment efforts, cultivated a structured environment for PFAC meetings, and boosted participation and actionable feedback.
	CPC Classic Spotlight 9 & 10: CapitalCare Shares How It Operationalized 10 PFACs in 2013	This CPC Classic spotlight describes the CapitalCare Medical Group's implementation of its PFAC. CapitalCare's 10 CPC+ practices collectively decided the PFAC approach would provide up-close and actionable feedback that was specific to their sites, staff, and workflows.
	Using Patient Feedback to Drive Practice Change	In this CPC Classic on-demand video, hear how one CPC+ practice partners with its PFAC on patient education.
	IHI Partnering in Self-Management Support: A Toolkit for Clinicians	This toolkit and other resources help support self-management from both the practitioner and the patient side, and include diagrams, action plans, and presentations.
	Self-Management Toolkit: A Resource for Health Care Providers	This toolkit offers tutorials for practitioners to quickly learn self-management techniques and tools.
	Community Health Association of Mountain Plain States (CHAMPS) Patient Self-Management Tools	CHAMPS provides a library of condition specific self-management tools and links to online patient self-management resources to facilitate patients having a central role in determining their care and to foster a sense of self-responsibility for health and wellbeing.
	Patient-Centered Interactions: Engaging Patients in Health and Healthcare	This implementation guide to improving patient-centered interactions includes use of surveys, self-management support (SMS), and organizing patient-centered visits.

Type	Title	Description
	Helping Patients Help Themselves: How to Implement Self-Management Support	This guide from the California Healthcare Foundation cites seven essential SMS activities.
	CPC Classic Spotlight 33: Check for Literacy When Evaluating Patient Self-Management Skills – Warren Clinic	This CPC Classic spotlight describes the Warren Clinic's implementation of SMS and its methods for evaluation of patient literacy and self-management skills.
	CPC Classic Spotlight 43: Beyond Patient Education: Self-Management Support	This CPC Classic spotlight describes how Hunterdon Family Practice & Obstetrics engages patients in SMS by way of a structured SMS visit where patients are guided to take the lead on improving their health through appropriate goal setting, planning strategies to overcome barriers, and using the practice's guidance and support.
	CPC Classic Spotlight 76: Strategies for Meeting Patients 'Where They Are' and Making Self-Management Support Work in a Busy Primary Care Practice	This CPC Classic spotlight describes how everyone at Summit Family Physicians is part the practice's SMS team. Mark Frazer, MD, explains how a prepared and engaged clinic team helps daily schedules stay on track and improves the patient's experience.
	The Effective Physician: Motivational Interviewing Demonstration	This video provides a demonstration of the motivational interviewing approach in a brief medical encounter.
	Always Use Teach-back Training Toolkit	This toolkit includes videos and tools using teach-back to confirm understanding, with behavior change principles of coaching to new habits and adapting systems to promote consistent use of key practices.
	The Patient Activation Measure (PAM)	This tool identifies the patient's level of activation, which can then guide the care team in the planning of care with the patient. Any team member can quickly use this tool with a patient. Note: This tool is a commercial product with a licensing fee associated with its usage.
	How's Your Health	This assessment tool can be completed by the patient. It measures his or her level of confidence in managing a chronic condition, and provides guidance in building a plan that improves confidence.
	The AHRQ SHARE Approach to Shared Decision Making	AHRQ's SHARE Approach is a five-step process for shared decision making that includes exploring and comparing the benefits, harms, and risks of each option through meaningful dialogue about what matters most to the patient. This web-based resource includes curriculum on the SHARE approach, patient decision aids, case studies, and guidelines.

Type	Title	Description
	Mayo Clinic Shared Decision Making National Resource Center	The Mayo Clinic Shared Decision Making National Resource Center advances patient-centered medical care by promoting shared decision making through the development, implementation, and assessment of patient decision aids and shared decision making techniques. This web-based resource includes decision aids, training materials, case studies, presentations, and videos.
	Center for Shared Decision Making	The Center for Shared Decision Making at Dartmouth Institute offers training modules, toolkits, and resources for integrating decision support into primary care, specialty care, and clinical skills.
	Value of shared decision making	This four-minute educational video by St. John Health System explores the concept of shared decision making using the SHARE approach.
	CPC Classic Spotlight 14: Hicken Medical Clinic	This CPC Classic spotlight describes the Hicken Medical Clinic's shared decision making approach and workflow for shared decision making for patients.
	CPC Classic Spotlight 4: Primary Care Partners	This CPC Classic spotlight features Dr. Pramenko, who discusses how Primary Care Partners' journey with shared decision making began and what work still lies ahead to fully integrate shared decision making in primary care.

Function 5: Planned Care and Population Health Resources

Type	Title	Description
	Implementing a point-of-care registry	This guideline provides how-to steps for brainstorming point of care registries, as well as templates and examples of completed registries.
	Team-based relationship resource	This resource provides a team-based planning worksheet to guide you in your patient care evaluation.
	An Organized Approach to Chronic Disease Care	This article highlights a practice that implemented a chronic care model. The article outlines the baseline data, team-based roles and responsibilities, and outcome measures for improving chronic care for high-risk diabetic patients.
	IHI: Optimize the Care Team	This resource guide provides guiding steps for a practice to understand the types of services it provides, and then decide who should be involved in the work and how practices should divide the work among the care team.

Type	Title	Description
	CPC Classic Spotlight 58: Setting Your Improvement Project in Motion: Get a Quick Start with Pre-Planning, Guidelines, Communication and Tools	This CPC Classic spotlight describes how Colorado's Family Physicians of Greeley implemented strategies to earn provider buy-in and support for a short-term quality improvement project focused on early identification and preventive treatment for COPD.
	CPC Classic Spotlight 86: Pre-visit Planning Helps Eliminate Gaps in Patient Care	This CPC Classic spotlight highlights how Upper Valley Family Care in Ohio uses a well-coordinated system of pre-visit planning to eliminate gaps in patient care.
	CPC+ Team-Based Care Learning and Action Summary	This CPC+ Learning and Action Summary pulls together the guidance and resources shared during various learning events and organizes content, so that you can easily reference materials as you implement team-based care to meet the needs of your patient population.
	CPC Classic Spotlight 39: Care Team as a Partner in Wellness	This CPC Classic spotlight explores Dr. Borghini's approach to help patients set attainable goals and make a measurable difference in their health.

Driver 2: Use of Enhanced, Accountable Payment Resources

Type	Title	Description
	Estimating the Costs of Primary Care Transformation, A Practical Guide and Synthesis Report	This guide lists the key steps in an analysis of the costs of a primary care transformation effort, reviews the range of methodological options, and describes key considerations for each method.
	Practice Management Toolkit	This toolkit assists practices in: 1) building financial reports; 2) evaluating payers, including payer profitability and collections monitoring; 3) fee schedule tracking; and 4) cost-benefit analysis for adding new services
	CPC+ Financial Reporting Fact Sheet	This fact sheet is a quick overview of information needed to collect and track for submitting forecasted and actual revenue for CPC+.
	What You Need to Know About Financial Reporting for CPC+	In this webinar, CMS and the National Learning Team review the CPC+ financial reporting requirements and interview experienced practices on how they prepare, including what strategies they use, along with tips and tricks!
	CPC+ Financial Reporting Guide	This guide provides a reporting schedule, key definitions and instructions for submitting your forecasted and actual CPC+ revenue in the CPC+ Practice Portal.

Type	Title	Description
	CPC Classic Practice Spotlight 1 & 2: SAMA Healthcare	This CPC Classic spotlight highlights how SAMA Healthcare Services leveraged CPC dollars to re-configure its clinic's staff into four care teams, each led by a physician and supported by a Nurse Practitioner, three additional nurses, and a care coordinator. The funding allowed SAMA to hire the needed Nurse Practitioners, including one who is a certified diabetes educator and another with a pediatrics specialty certification.
	CPC Classic Practice Spotlight 31: Building a Transformative Culture to Sustain Change	This CPC Classic spotlight explores how this 39-site practice group has sought ways to stave off "change fatigue" by cultivating engagement and incorporating compensation strategies that reward value and team-based care. Find out how their patients are responding to a staff of empowered and knowledgeable practitioners.
	CPC Classic Spotlight 44: Teamwork, Transparency and Rewards Drive Improvement in Quality Measures	This CPC Classic spotlight describes how PriMed pursued three strategies to help physicians and their teams adapt and embrace integrating the CPC CQMs: teamwork, data transparency, and rewards for performance. PriMed developed compensation strategies that recognized high performers at meetings and practice events, as well as through financial incentives.

Driver 3: Continuous Improvement Driven by Data Resources

Type	Title	Description
	IHI Run Chart Tool	This resource offers a guide to run charts and an Excel template for practice use. Registration on the IHI site is free.
	Using Run and Control Charts to Understand Variation	This resource from IHI Open School provides videos about run charts and how to construct this visual of data for evaluating variation or change. Also included are explanations of run chart rules and the use of run charts.
	CPC+ Spotlight 6: Quality Improvement through eCQM Checklist Implementation and Patient Outreach	This spotlight focuses on improvements in quality made by Stillwater Medical Clinic, Oklahoma, through implementation of eCQM checklists and patient outreach.
	CPC Classic Spotlight 37: Taking a Second Look at Medicare Utilization Data for Improvement Opportunities in Admissions and ED Use	This spotlight highlights the work of Family Physicians of Greeley, Colorado, using run charts to monitor improvement efforts.

Type	Title	Description
	CPC Classic Spotlight 41: Following Data Over the Long-Term Aids in Maintaining Improvement	This spotlight highlights the work of Central Oregon Family Medicine on tracking referral related metrics and using the data for improvement by looking for patterns and changes.
	CPC Classic Spotlight 70: Practice 'Re-attacks' ED Visits Following Changes in the Medical Neighborhood	Despite sustained improvements in several key Medicare outcomes, Harrison Family Practice was puzzled to see its patients' ED visits start to climb around Q5. Read this CPC+ spotlight to find out how the practice searched for root causes and how it is "re-attacking" ED visits.
	CPC Classic Spotlight 71: Practice Credits Culture for Sustained Improvements	This CPC+ spotlight features Scotia-Glenville Family Medicine, which consistently ranks among the practices with the lowest expenditures in the New York region. Practice leaders credit a culture of putting patients' needs first for gains in its transformational efforts. A deeper look reveals data helps identify those patient needs, which autonomous care teams then support. A full complement of care management services then backs up those teams. The result is responsive, timely care for a range of patient needs.
	CPC Classic Spotlight 73: Utica Park Clinic: CPC from the Leader's Perspective	This CPC+ spotlight describes Utica Park Clinic's approach to improving care by teambuilding and spreading and embracing change.
	CPC Classic Spotlight 31: Building a Transformative Culture to Sustain Change	This CPC+ spotlight explores how Providence Medical Group, a 39-site practice group, sought ways to stave off "change fatigue" by cultivating engagement and building a culture focused on continual improvement. Find out how this practice's patients are responding to a staff of empowered and knowledgeable practitioners.
	CPC Classic Spotlight 62: Marrying Actionable Data with Better Operations to Improve Care	Eugene Heslin, MD, describes how his CPC+ practice has tackled the challenges of transformation, leveraging data to build better operations. This CPC+ spotlight discusses how Bridge Street Family Medicine marries utilization and improvement with quality care and patient satisfaction.
	Approaches to Quality Improvement	This guide describes how the model for improvement and Plan-Do-Study-Act cycle provides a framework to systematically improve the way care is delivered to patients.

Driver 4: Optimal Use of Health IT Resources

Type	Title	Description
	CPC Classic Spotlight 1: SAMA Healthcare	Read about how CPC+ practice, SAMA Healthcare from El Dorado, Arizona, used the risk stratification capability of its EHR and blended it with care management to improve preventive care services.
	Certified Health IT Product List (CHPL)	This website lists all certified health IT vendors and versions.
	Testing and Test Methods	The Office of the National Coordinator (ONC) HealthIT.gov website provides detailed information on all 2015 Edition certification criteria, companion guides, and test procedures.
	Common Clinical Data Set (CCDS) Reference Document	This resource is a complete list of the 2015 Edition of the Common Clinical Data Set (CCDS) and their associated standards
	CDA® Release 2	This document standard developed by the HL7 organization specifies the structure and semantics of clinical documents for health care data exchange.

Driver 5: Aligned Payment Reform Resource

Type	Title	Description
	CPC+ Payment Methodologies paper	This Executive Summary provides an overview of the methodologies that uses for the CPC+ payment model being tested in Medicare fee-for-service (FFS).

Appendix C. CPC+ 2018 Roadmap and Requirements

The tables below illustrate a “roadmap” for this year’s care delivery redesign. The roadmap illustrates suggested goals that you may want to consider as you are prioritizing your efforts this year. Below are also suggested sequencing of high-level changes that may lead to the enhanced capabilities required in CPC+ for new Program Year 2 requirements. Practices may be at different stages of readiness at the start of CPC+, and should look to this roadmap as a guide for pacing change. Depending on the specific corridor of work, your practice may be more advanced in one domain than in another. Your practice can start at the stage appropriate to its own needs and resources. By the end of Program Year 2, you should have fulfilled—and even moved beyond—the year’s care delivery requirements and be ready to advance to the next steps of redesign.

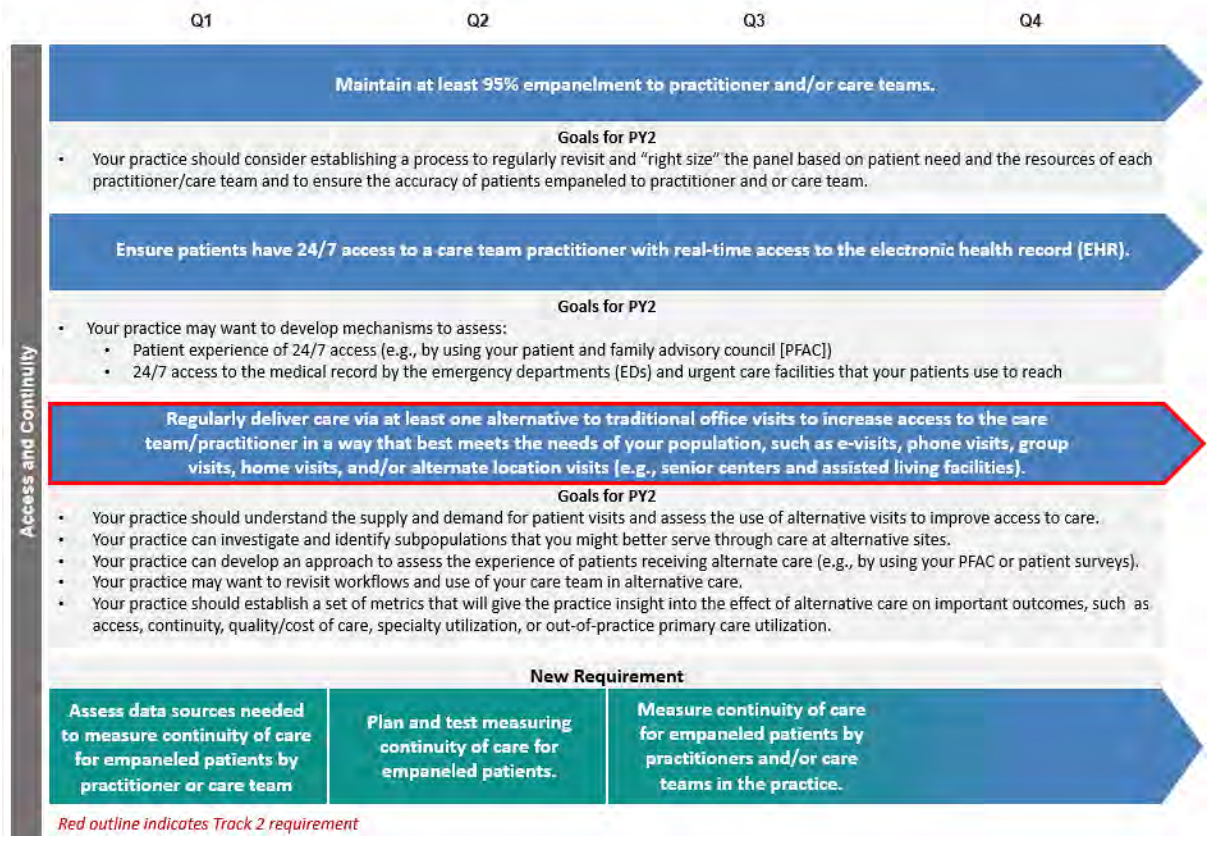
There are many choices your practice will make around how you focus your efforts to transform your care with the new resources available. Remember—focus on what matters most for your patients and community, and build in processes to sustain changes that can improve coordination and reduce gaps in care.

As you sequence your work, it is critical to focus on the following critical, complex, and continuous tasks, as these have the best evidence of achieving the CPC+ aims and improving care for patients:

- Ensure that you have fully empaneled your patient population
- Risk stratify your patients and achieve high levels of successful outreach to patients with complex needs, through longitudinal care management and behavioral health integration
- Focus on coordinating care for patients undergoing transitions of care by offering reliable and robust episodic care management
- Improve access and continuity through tracking and alternative to traditional face-to-face office visits. Find ways to improve connections to community resources and specialists
- Engage patients in improving their own care through self-management support and patient-family advisory councils
- Choose a few high-value quality measures that matter to track and improve your patients’ health in a standardized way

PY 2 Practice Roadmap and Goals (2017 Starters)

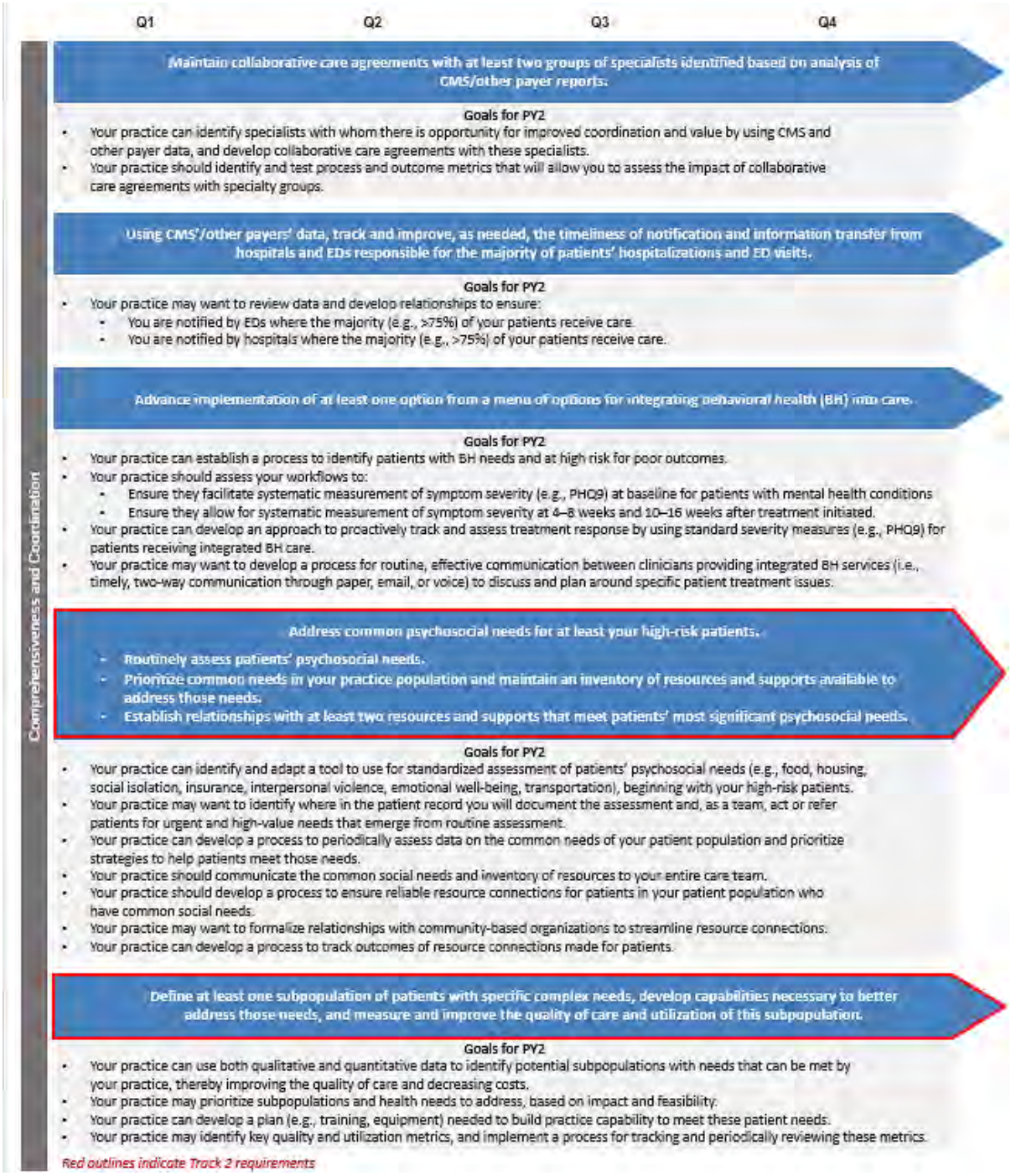
Access and Continuity

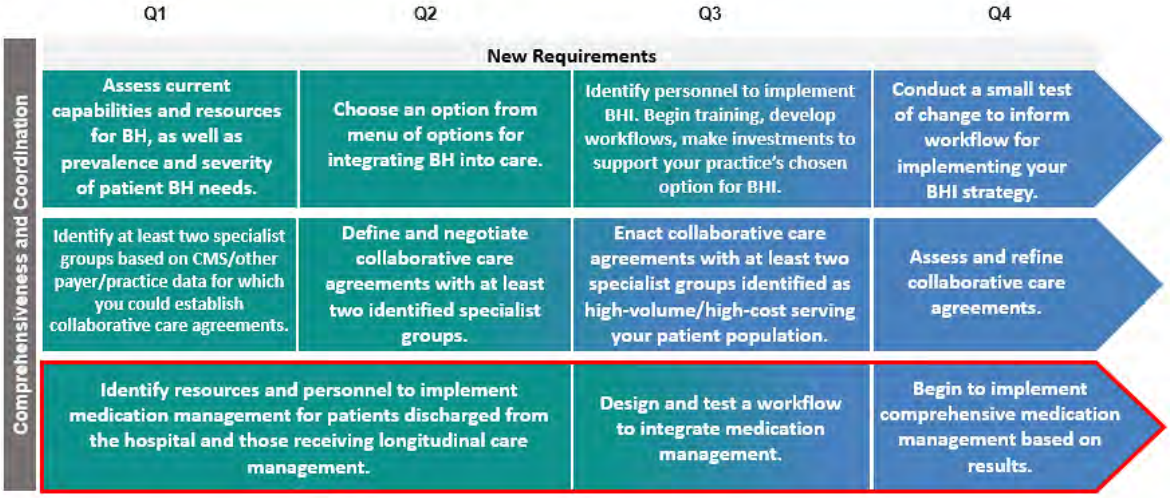


Care Management

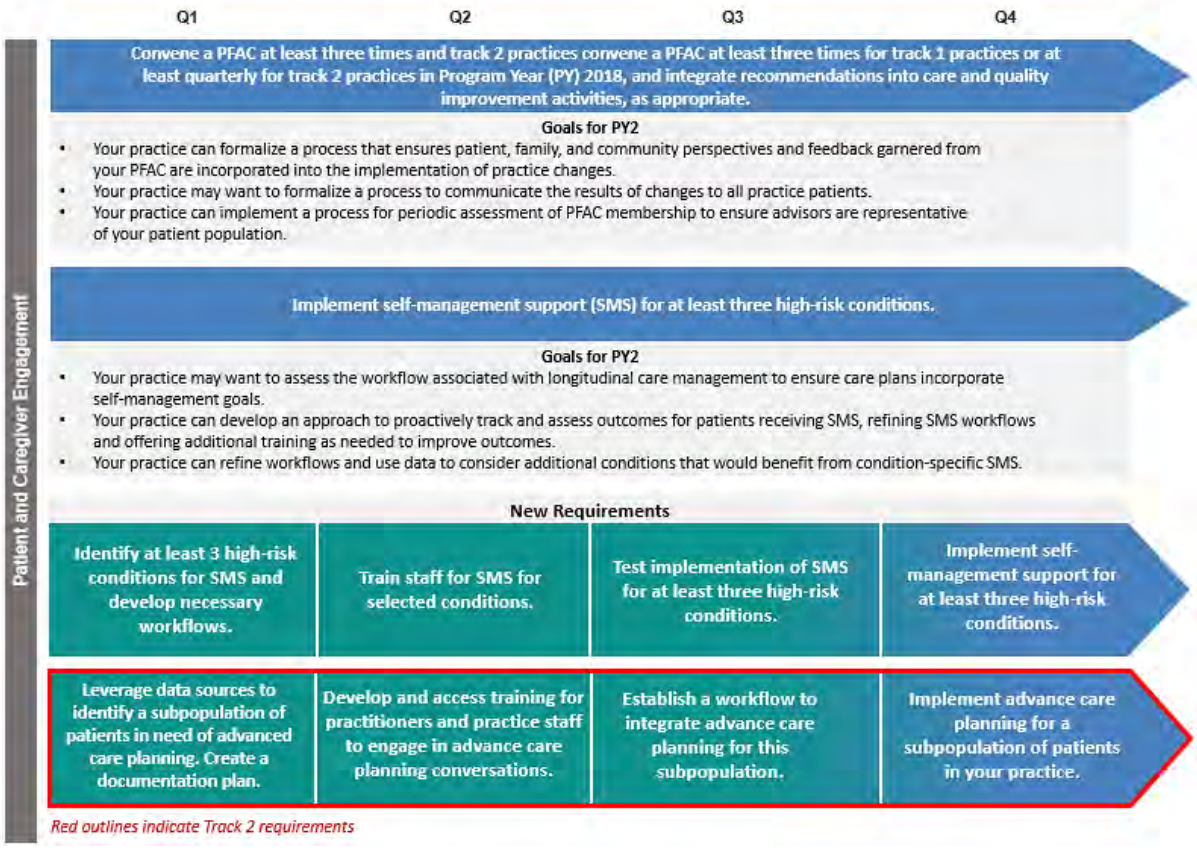
Red outline indicates Track 2 requirement

Comprehensiveness & Coordination

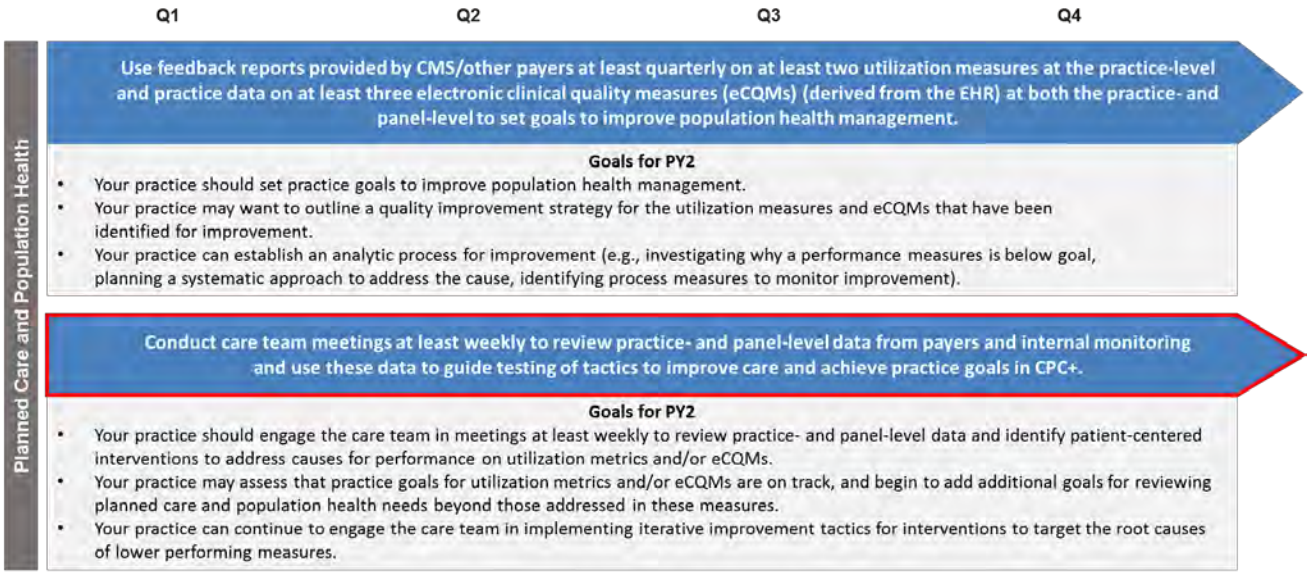




Patient & Caregiver Engagement

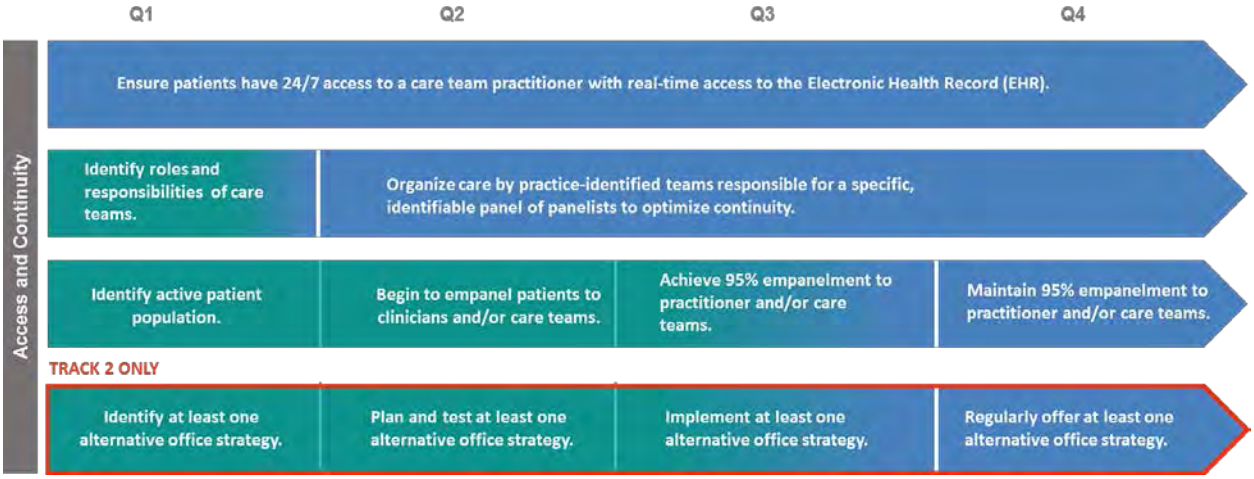


Planned Care & Population Health

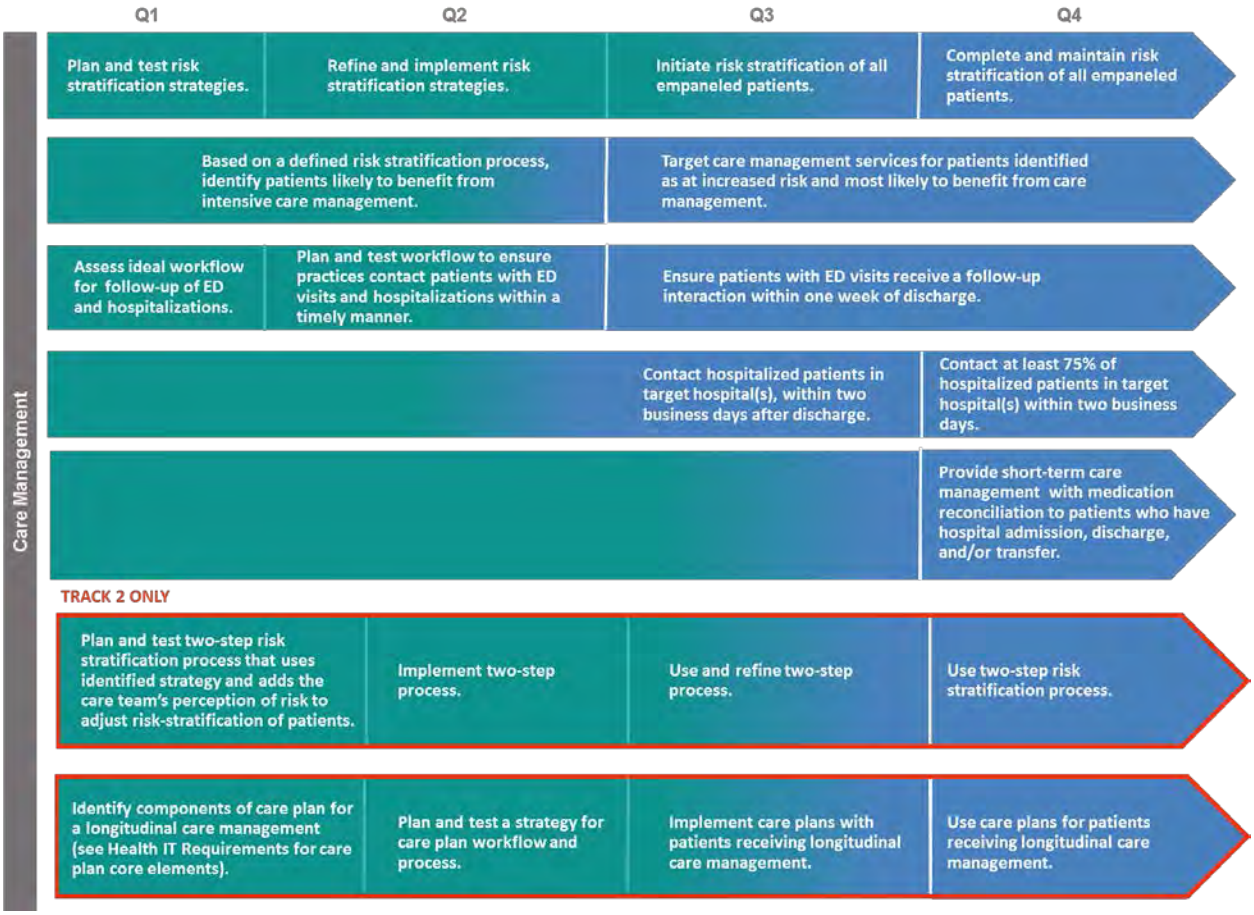


PY 1 Practice Roadmap (2018 Starters)

Access and Continuity

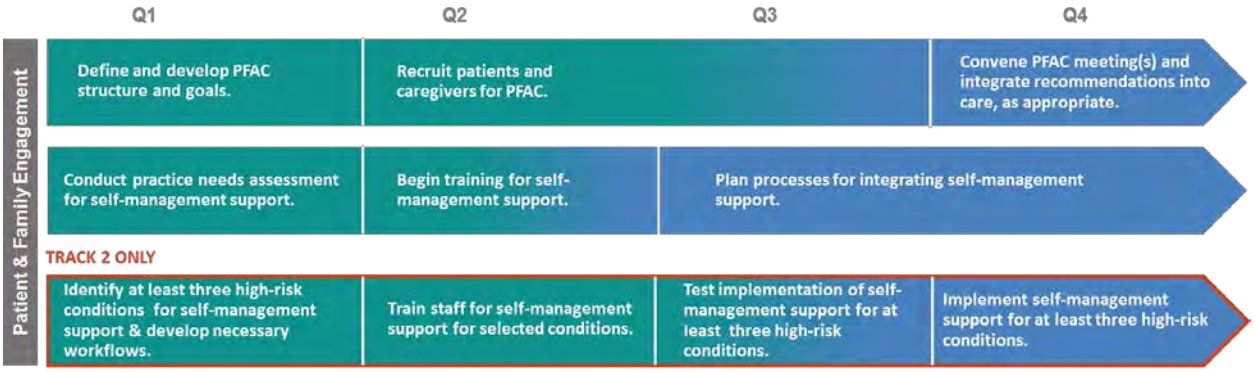


Care Management

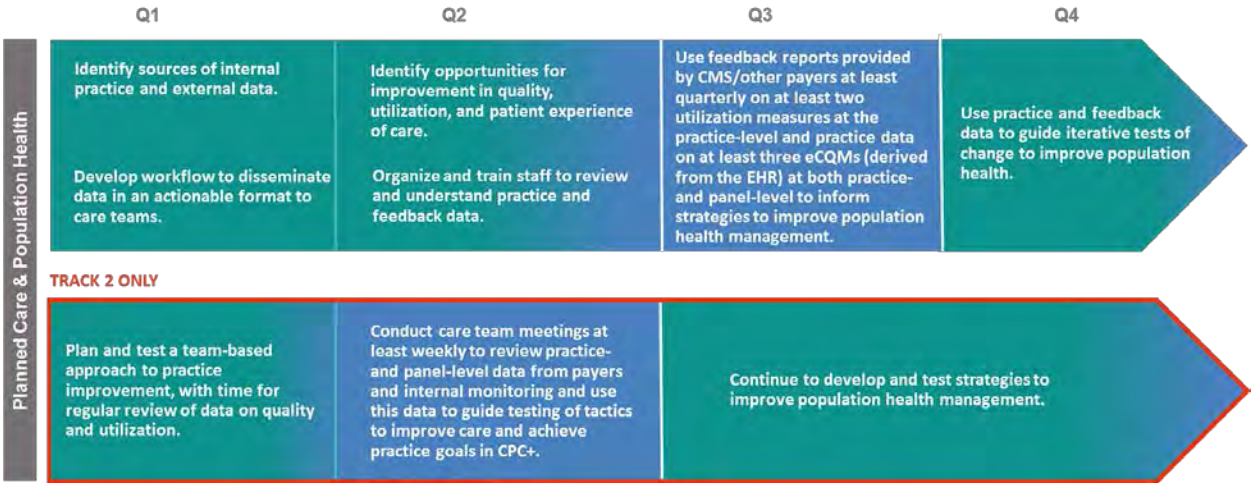


Comprehensiveness and Coordination

Patient and Caregiver Engagement



Planned Care and Population Health



Track 1 Program Year 1 and 2 Requirements

Function	Program Year 1 Requirements	Program Year 2 Requirements
1 Access and Continuity	1.1 Achieve and maintain at least 95% empanelment to practitioner and/or care teams. 1.2 Ensure patients have 24/7 access to a care team practitioner with real-time access to the electronic health record (EHR). 1.3 Organize care by practice-identified teams responsible for a specific, identifiable panel of patients to optimize continuity.	1.1 Maintain at least 95% empanelment to practitioner and/or care teams. 1.2 Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR. 1.3 Measure continuity of care for empaneled patients by practitioners and/or care teams in the practice.
2 Care Management	2.1 Risk stratify all empaneled patients. 2.2 Provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, based on a defined risk stratification process and who are likely to benefit from intensive care management. 2.3 Provide short-term (episodic) care management along with medication reconciliation to a high and increasing percentage of empaneled patients who have an emergency department (ED) visit or hospital admission/discharge/transfer and who are likely to benefit from care management. 2.4 Ensure patients with ED visits receive a follow-up interaction within one week of discharge. 2.5 Contact at least 75% of patients who are hospitalized in target hospital(s), within two business days.	2.1 Use a two-step risk stratification process for all empaneled patients, addressing medical need, behavioral diagnoses, and health-related social needs: Step 1. Use an algorithm based on defined diagnoses, claims, or other electronic data allowing population-level stratification; and Step 2. Add the care team's perception of risk to adjust the risk stratification of patients, as needed. 2.2 Based on your risk stratification process, provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, and likely to benefit from intensive care management. 2.3 Provide short-term (episodic) care management, including medication reconciliation, to patients following hospital admission/discharge/ transfer (including observation stays) and, as appropriate, following an ED discharge. 2.4 Ensure patients with ED visits receive a follow-up interaction within one week of discharge.

Function	Program Year 1 Requirements	Program Year 2 Requirements
		2.5 Contact at least 75% of patients who were hospitalized in target hospital(s) (including observation stays) within two business days.
3 Comprehensiveness and Coordination	3.1 Systematically identify high-volume and/or high-cost specialists serving the patient population using CMS/other payers' data. 3.2 Identify hospitals and EDs responsible for the majority of your patients' hospitalizations and ED visits, and assess and improve timeliness of notification and information transfer using CMS/other payers' data.	3.1 Enact collaborative care agreements with at least two groups of specialists identified based on analysis of CMS/other payer reports. 3.2 Using CMS'/other payers' data, track timeliness of notification and information transfer from hospitals and EDs responsible for the majority of your patients' hospitalizations and ED visits. 3.3 Develop a plan for implementation of at least one option from a menu of options for integrating behavioral health into care, based on an assessment of practice capability and population need.
4 Patient and Caregiver Engagement	4.1 Convene a patient and family advisory council (PFAC) at least once in Program Year 1 and integrate recommendations into care, as appropriate. 4.2 Assess practice capability and plan for support of patients' self-management.	4.1 Convene a PFAC at least three times in Program Year 2 and integrate recommendations into care and quality improvement activities, as appropriate. 4.2 Implement self-management support for at least three high-risk conditions.
5 Planned Care and Population Health	5.1 Use feedback reports provided by CMS/other payers at least quarterly on at least two utilization measures at the practice-level and practice data on at least three electronic clinical quality measures (eCQMs) (derived from the EHR) at both practice- and panel-level to improve population health management.	5.1 Use feedback reports provided by CMS/other payers at least quarterly on at least two utilization measures at the practice-level and practice data on at least three electronic clinical quality measures (derived from the EHR) at both the practice- and panel-level to set goals to improve population health management.

Track 2 Program Year 1 and 2 Requirements

Function	Program Year 1 Requirements	Program Year 2 Requirements
1 Access and Continuity	1.1 Achieve and maintain at least 95% empanelment to practitioner and/or care teams. 1.2 Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR. 1.3 Organize care by practice-identified teams responsible for a specific, identifiable panel of patients to optimize continuity. 1.4 Regularly offer at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population, such as e-visits, phone visits, group visits, home visits, alternate location visits (e.g., senior centers and assisted living facilities), and/or expanded hours in early mornings, evenings, and weekends.	1.1 Maintain at least 95% empanelment to practitioner and/or care teams. 1.2 Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR. 1.3 Measure continuity of care for empaneled patients by practitioners and/or care teams in the practice. 1.4 Regularly deliver care in at least one way that is an alternative to traditional office visit-based care, meets the needs of your patient population, and increases access to the care team/practitioner, such as e-visits, phone visits, group visits, home visits, and/or alternate location visits (e.g., senior centers and assisted living facilities).

Function	Program Year 1 Requirements	Program Year 2 Requirements
2 **Care Management**	2.1 Use a two-step risk stratification process for all empaneled patients: Step 1. Based on defined diagnoses, claims, or another algorithm (i.e., not care team intuition). Step 2. Adds the care team's perception of risk to adjust the risk stratification of patients, as needed. 2.2 Provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, based on a defined risk stratification process and who are likely to benefit from intensive care management. 2.3 Provide short-term (episodic) care management along with medication reconciliation to a high and increasing percentage of empaneled patients who have an ED visit or hospital admission/discharge/ transfer and who are likely to benefit from care management. 2.4 Ensure patients with ED visits receive a follow up interaction within one week of discharge. 2.5 Contact at least 75% of patients who are hospitalized in target hospital(s), within two business days. 2.6 Use a plan of care centered on patient's actions and support needs in management of chronic conditions for patients receiving longitudinal care management.	2.1 Maintain and review a two-step risk stratification process for all empaneled patients, addressing medical needs, behavioral diagnoses, and health-related social needs: Step 1. Use an algorithm based on defined diagnoses, claims, or other electronic data allowing population-level stratification; and Step 2. Add the care team's perception of risk to adjust the risk stratification of patients, as needed. 2.2 Based on your risk stratification process, provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, and likely to benefit from intensive care management. 2.3 For patients receiving longitudinal care management, use a plan of care containing at least patients' goals, needs, and self-management activities that can be routinely accessed and updated by the care team. 2.4 Provide short-term (episodic) care management, including medication reconciliation to patients following hospital admission/discharge/transfer, (including observation stays) and, as appropriate, following an ED discharge. 2.5 Ensure patients with ED visits receive a follow-up interaction within one week of discharge. 2.6 Contact at least 75% of patients who were hospitalized in target hospital(s) (including observation stays) within two business days.

Function	Program Year 1 Requirements	Program Year 2 Requirements
3 Comprehensiveness and Coordination	3.1 Systematically identify high-volume and/or high-cost specialists serving the patient population using CMS/other payers' data. 3.2 Identify hospitals and EDs responsible for the majority of your patients' hospitalizations and ED visits, and assess and improve timeliness of notification and information transfer using CMS/other payers' data. 3.3 Enact collaborative care agreements with at least two groups of specialists, identified based on analysis of CMS/other payer reports. 3.4 Choose and implement at least one option from a menu of options for integrating behavioral health into care. 3.5 Systematically assess patients' psychosocial needs using evidence-based tools. 3.6 Conduct an inventory of resources and supports to meet patients' psychosocial needs. 3.7 Characterize important needs of subpopulations of high-risk patients and identify a practice capability to develop that will meet those needs, and can be tracked over time.	3.1 Maintain collaborative care agreements with at least two groups of specialists identified based on analysis of CMS/other payer reports. 3.2 Using CMS/other payers' data, track and improve, as needed, the timeliness of notification and information transfer from hospitals and EDs responsible for the majority of your patients' hospitalizations and ED visits. 3.3 Develop a plan to provide comprehensive medication management to patients discharged from the hospital and those receiving longitudinal care management. 3.4 Advance implementation of at least one option from a menu of options for integrating behavioral health into care. 3.5 Address common psychosocial needs for at least your high-risk patients: • Routinely assess patients' psychosocial needs. • Prioritize common needs in your practice population, and maintain an inventory of resources and supports available to address those needs. • Establish relationships with at least two resources and supports that meet patients' most significant psychosocial needs. 3.6 Define at least one subpopulation of patients with specific complex needs, develop capabilities necessary to better address those needs, and measure and improve the quality of care and utilization of this subpopulation.

Function	Program Year 1 Requirements	Program Year 2 Requirements
4 Patient and Caregiver Engagement	4.1 Convene a PFAC in at least two quarters in PY 2017 and integrate recommendations into care, as appropriate. 4.2 Implement self-management support for at least three high risk conditions.	4.1 Convene a PFAC at least quarterly in PY 2, and integrate recommendations into care and quality improvement activities, as appropriate. 4.2 Implement self-management support for at least three high-risk conditions. 4.3 Identify and engage a subpopulation of patients and caregivers in advance care planning.
5 Planned Care and Population Health	5.1 Use feedback reports provided by CMS/other payers at least quarterly on at least two utilization measures at the practice-level and practice data on at least three electronic clinical quality measures (derived from the EHR) at both practice- and panel-level to improve population health management. 5.2 Conduct care team meets at least weekly to review practice- and panel-level data from payers and internal monitoring and use this data to guide testing of tactics to improve care and achieve practice goals in CPC+.	5.1 Use feedback reports provided by CMS/other payers at least quarterly on at least two utilization measures at the practice-level and practice data on at least three electronic clinical quality measures (derived from the EHR) at both the practice- and panel-level to set goals to improve population health management. 5.2 Conduct care team meetings at least weekly to review practice- and panel-level data from payers and internal monitoring and use this data to guide testing of tactics to improve care and achieve practice goals in CPC+.

Appendix D. Health IT Requirements

CPC+ Certified Health IT Requirements

Overall CEHRT Adoption

Requirement	Date	Notes
Adopt and maintain,[69] at a minimum, health IT needed to meet the certified EHR technology (CEHRT) definition required by the Quality Payment Program (QPP) at 42 CFR 414.1305.[70]	No later than January 1 for each program year	N/A

Certified Health IT for Quality Reporting

Requirement	Date	Notes
Adopt and maintain, at a minimum, health IT meeting the definition of CEHRT required by the QPP at 42 CFR 414.1305 for electronic clinical quality measure (eCQM) reporting,[71] using the most recent update available on January 1 of the measurement period, for the eCQMs in the CPC+ measure set.[72]	No later than January 1 for each program year	For each measurement period, practices must use the eCQM specifications for eReporting listed in the eCQI Resource Center as of January 1 of the program year.
Adopt and maintain the **2015 Edition** certification criterion found at 45 CFR 170.315(c)(4)[73] to filter eCQMs for reporting at the CPC+ Practice Site level, as defined by practice site location, TIN, and NPI(s).	No later than **December 31, 2018**. (Please note that this is a specific date, not a program year.)	Practices do not need to have access to technology that meets the (c)(4) filter certification criterion until December 31, 2018, however, they will be expected to have access to technology with the capability to filter data for reporting at the CPC+ practice site level as defined by practice site location, TIN, and NPI(s), to support quality improvement activities during the program year.

[69] For clarity, CPC+ requires adoption of relevant health IT for the entire program year, unless otherwise specified. For instance, if an upgrade to a new edition of certified technology is required to meet the CEHRT definition for a given year, the upgrade must be completed by January 1. Other CMS programs may allow adoption for less than 12 months; CPC+ is different.

[70] The CEHRT definition finalized in the CY 2018 QPP Final Rule at 42 CFR 414.1305 allows for the use of the 2014 and/or 2015 Editions of certified health IT. CPC+ practices may use 2014 Edition, 2015 Edition, or a combination of the two throughout the 2018 calendar year, except as specified in the Certified Health IT for Quality Reporting section of these requirements.

[71] In the current definition of CEHRT required by the QPP at 42 CFR 414.1305, 45 CFR 170.315(c)(1)-(c)(3) refers to 2015 Edition CEHRT, while 45 CFR 170.314(c)(1)-(c)(3) refers to 2014 Edition CEHRT. For each of these sections, (c)(1) is the certification criterion for "Record and Export;" (c)(2) is the certification criterion for "Import and Calculate;" and (c)(3) is the certification criterion for "Report."

[72] Please note that the CPC+ Quality Reporting Requirements for the current program year can be accessed on CPC+ Connect. Per the CPC+ Request for Applications and practice-facing Participation Agreement, the final measure list and requirements for each program year will be communicated to practices in advance.

[73] Under the 2015 Edition of certified health IT, 45 CFR 170.315(c)(4) is the certification criterion for "CQMs – filter."

Additional Certified Health IT for Track 2

Requirement	Date	Notes
TRACK 2 ONLY: Adopt and maintain health IT certified to the 2015 Edition "Care Plan" criterion found at 45 CFR 170.315(b)(9).	No later than January 1 Program Year 3	Adoption of this capability will support enhanced health IT functionality for Track 2 practices, as described below.
TRACK 2 ONLY: Adopt and maintain health IT certified to the 2015 Edition "Social, Behavioral and Psychological Data" criterion found at 45 CFR 170.315(a)(15).	No later than January 1 Program Year 3	Adoption of this capability will support enhanced health IT functionality for Track 2 practices, as described below.

Health IT Functionalities/Enhancements for Track 2

CMS will ask practices in Track 2, supported by participating vendors, to develop the following health IT functions/enhancements. CMS will not prescribe how the health IT enhancement is accomplished; rather, only that the health IT solution meets the CPC objective for use of the health IT by the CPC+ Practice Site team. CMS anticipates that practices will complete some of these requirements in the first 6 to 12 months of model start-up, while others will take longer. CMS expects that practices will complete all health IT enhancements listed below no later than 24 months after practices start their first program year (e.g., January 1, 2019).

Program Years 1 and 2[74]

Technical Enhancement	Timeline for Adoption	Objective for Use
Empanel patients to the practice site care team	No later than July 1 Program Year 2	1. Enable the practice to assign each patient to a care team or practitioner and sort and review the patients by assignment. 2. The assigned provider should be visible in the patient record to members of the care team.
Risk stratify practice site patient population; identify and flag "Patients with Complex Needs"	No later than July 1 Program Year 2	1. Enable the practice site to assign a risk score/label that reflects assignment based on the practice's risk stratification methodology. 2. The methodology used to stratify practices should be clear and meet basic guidelines established by CMS.[75] 3. The practice site care team should be able to sort patients by score and update risk scores as needed. 4. Based on risk stratification results, the practice site should be able to flag patients it identifies as "complex patients" and/or as requiring episodic, short-term care management, and generate reports or lists of patients using those labels to support clinic workflow.
Produce and display eCQM results at the practice level[76] to support continuous feedback	No later than July 1 Program Year 2	1. Enable the entire practice team to view eCQM results at the practice site level to support continuous feedback on quality improvement efforts. 2. Measure results should be updated as frequently as possible so that measures reflect current progress. 3. This capability should present results in a usable, actionable manner that the care team can use to effectively manage population health.

[74] These requirements do not require the adoption of technology that meets a specific ONC certification criterion.
[75] The risk stratification methodology should include an algorithmic component, as well as an aspect of clinical intuition that can enhance or override the algorithmic risk score, and risk stratification should be performed on the entire active practice site patient population, not just the attributed Medicare beneficiaries.
[76] Practice site level refers to the CPC+ practice site location, TIN, and NPI(s).

Program Year 3 and Beyond

Technical Enhancement	Timeline for Adoption	Objective for Use
Systematically assess patients' psychosocial needs and inventory resources and supports to meet those needs	No later than January 1 Program Year 3	1. Enable primary care practices to electronically assess patients' psychosocial needs. 2. Enable primary care practices to capture or access electronically an inventory of resources and supports to meet patients' identified psychosocial needs. 3. To support this objective, practices must adopt certified health IT that meets the 2015 Edition criterion "Social, Behavioral and Psychological Data" found at 45 CFR 170.315(a)(15).
Establish a patient-focused care plan to guide care management	No later than January 1 Program Year 3	CPC+ practices should utilize an IT-enabled, patient-centered care planning tool to support holistic care and a focus on beneficiary goals and preferences. 1. Enable providers to electronically capture the following care plan elements: a. Advance directives and preferences for care b. Patient health concerns, goals, and self-management plans c. Action plans for specific conditions d. Interventions and health status evaluations and outcomes e. Identified care gaps 2. The practice should have the ability to customize which of these elements are included within the care plan and how these elements are displayed. 3. Providers should be able to incorporate relevant triggers (e.g., a risk score or event) that indicate different care management actions. 4. The care plan tool should facilitate version control across care team members by capturing the date of the last review or change in plan and generating a scheduled date for reviewing and updating the plan. 5. Practices should be able to populate the care plan using data entered in the patient's record (e.g., without duplicative data entry). 6. The care plan should be available to the patient on paper and electronically, and available in electronic format to care team members outside of the practice who are involved in the patient's care. Care plan information should also be remotely accessible to practice team members delivering care outside of normal business hours. 7. To support this objective, practices must adopt certified health IT that meets the 2015 Edition "Care Plan" criterion found at 45 CFR 170.315(b)(9).

Technical Enhancement	Timeline for Adoption	Objective for Use
Document and track patient reported outcomes	To be specified by CMS at a later date	CMS is evaluating a patient reported outcome survey instrument that will be sent to CPC+ Track 2 patients to identify specific care needs requiring intervention/ management by the CPC+ Practice Site team. CMS plans to use the data collected from the patient-reported outcome survey to develop a patient-reported outcome performance measure that may be included in CPC+ measure set in the later years of the model. The modes of administration are yet to be determined. 1. The health IT tool should provide the care team with the ability to administer the survey, store and track patient responses, and score results longitudinally for each patient surveyed. 2. The practice should be able to review the patient responses/results in its EHR or other health IT tool and, as appropriate, establish care plans/ interventions for positive findings.

Appendix E. CPC+ Health IT Definitions

1. Certified EHR Technology (CEHRT) Requirements

All CPC+ practices must use technology that meets the CEHRT definition finalized for the Quality Payment Program (QPP) at 42 CFR 414.1305 by January 1 of Program Year 1. This is a certified health IT requirement for both tracks of CPC+, and practices must maintain continuous use of CEHRT throughout the model. Practices must document the health IT vendor(s) that they use to meet CPC+ requirements in the CPC+ Practice Portal. This information must be updated by December 31 annually and whenever a practice changes or adds a new health IT vendor.

2. Use of CEHRT

Use of CEHRT means that all CPC+ practices use their EHR as their primary method of charting patient visits. All practitioners within a CPC+ practice must use CEHRT and record eCQM data in a structured format to ensure compliance with the practice-site level reporting. Optimal use of health IT is a foundational driver of the CPC+ model, and seamless integration of health IT into administrative workflows and care delivery is essential to the success of CPC+. Therefore, using a mixture of CEHRT and paper charts does not meet the "Use of CEHRT" definition, which is a requirement for both tracks of CPC+.

3. Certified Health IT for Quality Reporting

All CPC+ practices must ensure that they can generate an eCQM report using certified health IT that can filter data at the CPC+ practice site level, as defined by practice site location, CPC+ Tax Identification Number (TIN) and CPC+ National Provider Identifier(s) (NPI[s]). All CPC+ practices must adopt and maintain, at a minimum, a health IT vendor meeting the certification criteria found at 45 CFR 170.315 (c)(1)-(c)(3) for eCQM reporting, using the most recent update available on January 1 of the measurement period for all of the eCQMs in the CPC+ measure set.

In many cases, CPC+ practices will report eCQMs using their current CEHRT. However, practices may adopt additional certified health IT to meet these requirements, such as a certified registry. In addition, **no later than December 31, 2018**, practices must adopt and maintain certified health IT that meets the 2015 Edition certification criterion found at 45 CFR 170.315(c)(4). The (c)(4) criterion enables CPC+ practices to filter eCQMs for reporting at the practice site level. While practices have until December 31, 2018 to have access to technology that meets the (c)(4) filter certification, CMS expects practices to have access to technology that meets the CPC+ practice -site level reporting requirements during the program year.

While not required, CMS encourages practices to configure their certified health IT to be able to calculate and report all eCQMs in the CPC+ measure set. This will ensure that practices can still report the required nine eCQMs in the event CMS needs to remove one or more of the eCQMs from a measure set due to changes in clinical guidelines or problems with eCQM specifications.

Practices should refer to 2017 CPC+ Quality Reporting Requirements and preliminary 2018 CPC+ Quality Reporting Requirements for more information regarding CPC+ measure sets.

4. Track 2 Required Health IT for Advanced Health IT Functions

Track 2 practices have additional health IT requirements beyond those discussed in Sections 1 through 3 above. Track 2 practices applied to CPC+ with a Letter of Support from their health IT vendor(s), which attested that their health IT vendor(s) will support them in developing and implementing advanced health IT functions. The advanced health IT functions include the ability to:

- Risk stratify practice site patient population; identify and flag patients with complex needs (no later than July 1 of Program Year 2)
- Produce and display eCQM results at the practice level to support continuous feedback (no later than July 1 of Program Year 2)
- Empanel patients to the practice site care team (no later than July 1 of Program Year 2)
- Systematically assess patients' psychosocial needs and inventory resources and supports to meet those needs (no later than January 1 of Program Year 3, practices must adopt health IT certified to the 2015 Edition "Social, Behavioral, and Psychological Data" criterion found at 45 CFR 170.315(a)(15)).
- Establish a patient-focused care plan to guide care management (no later than January 1 of Program Year 3, practices must adopt health IT certified to the 2015 Edition "Care Plan" criterion found at 45 CFR 170(b)(9).
- Document and track patient reported outcomes (timeline to be specified by CMS at a later date)

The health IT vendors providing Track 2 practices with advanced health IT functions may also provide them with CEHRT, but this is not required. Some Track 2 practices may have multiple vendor(s): some that provide advanced health IT functions and others that provide CEHRT. The Vendor Letter of Support is **only** required for the vendor(s) providing the Track 2 Required Health IT for Advanced Health IT Functions. CMS will **only** sign a Memorandum of Understanding (MOU) with Track 2 health IT vendors. If CMS is unable to procure an MOU with a Track 2 CPC+ practice's health IT vendor, this practice will need to find a new health IT vendor with which CMS can sign an MOU. Please refer to the Vendor MOU policy for more information. Some health IT vendors have signed both a Global Vendor Letter of Support for CPC+ practices and an MOU with CMS, as these agreements apply to all practices using the vendors' technology.

Practices can refer to the list of all health IT vendors used by CPC+ practices. This list identifies health IT vendors that have signed an MOU with CMS, as well as those health IT vendors that have submitted a Global Vendor Letter of Support.

5. Other Health IT

CPC+ practices may use other health IT, such as billing software or systems that perform functions not required in the CPC+ care delivery model. Practices will not need to update the CPC+ Practice Portal with these other types of health IT, nor provide Vendor Letters of Support or MOUs from these other health IT vendors.

Appendix F. CPC+ Health IT Policies and Procedures

1. ALL PRACTICES: Maintaining Use of Certified Health IT

All CPC+ practices must use health IT meeting the certified EHR technology (CEHRT) definition finalized for the Quality Payment Program (QPP) at 42 CFR 414.1305 by January 1 of each program year and meet the "Use of CEHRT" definition throughout all CPC+ program years. All CPC+ practices must adopt and maintain, at a minimum, health IT meeting the certification criteria found at 45 CFR 170.315 (c)(1)-(c)(3) for eCQM reporting. Beginning **no later than December 31, 2018**, practices must adopt and maintain certified health IT that meets the 2015 Edition certification criterion found at 45 CFR 170.315(c)(4). These are certified health IT requirements for both tracks of CPC+, and practices must maintain continuous use of CEHRT throughout the model.

If at any time during the model, the practice does not meet the "Use of CEHRT" definition or stops using certified health IT without replacing with another certified health IT product via the process for transitioning health IT vendors, the practice will be out of compliance with the CPC+ health IT requirements listed in the Participation Agreement signed by the practice. In this case, CMS and CPC+ Support will take the following actions:

1. Day 0: CPC+ Support will send a courtesy email to the practice as soon as the certified health IT deficiency is determined, which is "day 0." The email will ask the practice to remediate the situation by adopting new certified health IT and meeting the "Use of CEHRT" definition, or risk termination from CPC+. The practice will be asked to provide additional information to CMS on the actions it is taking to remediate the situation in the next 30 calendar days. The practice must acknowledge the receipt of the email within five business days.

2. Day 30: If the practice has not remediated the situation after 30 calendar days, CMS will issue a CPC+ Performance Alert. The alert will stipulate that the practice will have 90 calendar days to address the lack of certified health IT and/or meet the "Use of CEHRT" definition.

3. Day 90: If the practice has failed to remediate the situation after 90 calendar days from the initial courtesy email, CMS will issue a Request for a Corrective Action Plan. Within the next 30 calendar days, the practice will be asked to submit a Corrective Action Plan addressing the steps it plans to take to ensure compliance with CPC+. The Corrective Action Plan may include a freeze on CPC+ payments until the issue is resolved.

4. Day 120: If after 120 calendar days from the initial courtesy email, the practice fails to complete the actions to remain in compliance with the *Maintaining Use of Certified Health IT* policy, CMS may remove the practice from CPC+. Once CMS terminates a practice, it is no longer eligible to participate in CPC+.

2. ALL PRACTICES: Transitioning Certified Health IT Vendor Used for Quality Reporting

A CPC+ practice may transition its certified health IT systems during CPC+ participation; however, transitioning health IT vendors while participating in CPC+ may affect a practice's ability to meet the quality reporting and health IT requirements. A practice must ensure that it can continue to meet CPC+ eCQM reporting and health IT requirements after implementation of a new certified health IT system. This may involve working with both legacy and new health IT vendors to:

- Arrange for data transfer between the two certified health IT systems
- Confirm the capability to generate a full CPC+ eCQM practice site-level report for the entire measurement period

If a practice is unable to report 12 months of data from the new health IT system, it must do one of the following after pre-approval from CMS:

1. If a practice cannot report 12 months of eCQM data for the measurement period, then CMS may accept as few as 9 consecutive months of eCQM data. A practice in this situation will be required to submit attested eCQM results via the CPC+ Practice Portal. Due to the shorter period of time being reported, eCQM performance results may be lower than expected. As a result, a practice may be required to return a greater portion of the Performance-Based Incentive Payment (PBIP) to CMS.
2. If a practice cannot report at least nine consecutive months of eCQM data for the measurement period, CMS may approve manual compilation of eCQM data from a combination of different health IT systems. To obtain approval, a practice must submit a manual compilation plan to CMS via CPC+ Support at CPCPlus@Telligen.com.

Note: A practice with a large health IT upgrade that disrupts its ability to report 12 months of data will have the same options listed above. A practice in this situation will have to follow the same process as a practice that is transitioning health IT vendors.

To meet the CPC+ eCQM reporting and health IT requirements, a practice must work closely with CPC+ Support. The CPC+ health IT policies and associated actions are described in more detail in the following sections. At a high level, the four policies pertain to the need for CPC+ practices to:

1. Provide initial notification of intent to transition to a new health IT vendor
2. Develop a comprehensive plan for health IT vendor transition
3. Develop and submit a manual compilation plan, if applicable
4. Provide immediate notification of any changes to the health IT vendor transition plan

Initial Notification Policy

Summary. A practice that is transitioning health IT must notify CMS at least three months prior to the transition.

Practices must notify CMS via email at CPCPlus@Telligen.com **at least three months** prior to the health IT vendor transition. Practices that transition health IT vendors voluntarily (to optimize processes) or involuntarily (through acquisition, merger, and/or organizational change) must provide notification of health IT vendor change. The practice will work closely with CPC+ Support on the health IT vendor transition request, which will be reviewed by CMS. For more information on the health IT vendor transition requests, see Appendix A of the CPC+ Health IT Transition Guide posted on CPC+ Connect.

Health IT Vendor Transition Plan Policy

Summary. A practice must present a comprehensive plan for health IT vendor transition to CMS at least two months prior to go-live.

CMS reviews and must approve every health IT vendor transition. As part of the health IT vendor transition, the practice will have to prepare and submit a transition plan **at least two months** prior to the go-live date with the new health IT vendor. CPC+ Support will work with the practice to complete the plan. CMS will review the transition plan and provide a formal notification of approval via email.

Manual Compilation of Data Policy

Summary. If manual compilation of data is required, the practice must submit a written manual compilation plan for review and approval by CMS within one month (+/- 30 calendar days) of the go-live date.

A practice that must combine data from two different health IT vendors manually to be able to submit a full CPC+ eCQM practice site-level report for the entire measurement period must submit a written manual compilation plan for review and approval by CMS. Practices can refer to Appendix B of the CPC+ Health IT Transition Guide posted on CPC+ Connect for the information to include in this plan. Practices may not proceed with this option without approval from CMS. The plan must be submitted to CPC+ Support **within a month** (+/- 30 calendar days) of the go-live date with the new health IT vendor.

Health IT Vendor Transition Plan Change Notification Policy

Summary. The practice must notify CPC+ Support of any changes to the health IT vendor transition request after CMS's approval.

If the practice's health IT vendor transition plans change, the practice must notify CMS **immediately** via email at CPCPlus@Telligen.com. Health IT vendor transition plan changes can

include changes to the implementation timeline, health IT vendors involved, and acquisition and/or merger of the health IT vendors. If health IT transition plans change, CMS must review and approve any changes to the health IT vendor transition plan.

If the practice is not able to report the required eCQM data, the practice may become ineligible for continued participation in CPC+. Any practice that fails to follow the policies described above will be considered out of compliance with the CPC+ Transitioning Certified Health IT Vendor Used for Quality Reporting health IT policy. CPC+ Support will conduct the following actions:

1. Day 0: CPC+ Support will send a courtesy email to the practice notifying it that one of the preceding health IT transition policies were not met, which is "day 0". The courtesy email will let the practice know which section of the *Transitioning Certified Health IT Vendor Used for Quality Reporting* health IT policy it does not meet and identify next steps to be completed in the next 30 calendar days. The practice must acknowledge the receipt of the email within five business days.

2. Day 30: If the practice has not remediated the situation after 30 calendar days, CMS will issue a CPC+ Performance Alert to the practice. This notice will stipulate that the practice will have 90 calendar days to address the required actions needed to be compliant with the *Transitioning Certified Health IT Vendor Used for Quality Reporting* health IT policy.

3. Day 90: If the practice has failed to remediate the situation after 90 calendar days from the initial courtesy email, CMS will issue a Request for Corrective Action Plan. Within the next 30 calendar days, the practice will be asked to submit a Corrective Action Plan addressing the steps it plans to take to ensure compliance with CPC+. The Corrective Action Plan may include a freeze on CPC+ payments until the issue is resolved.

4. Day 120: If after 120 calendar days from the initial courtesy email, the practice fails to complete the actions to remain in compliance with the *Transitioning Certified Health IT Vendor Used for Quality Reporting* health IT policy, CMS may remove the practice from CPC+. Once CMS terminates a practice, the practice is no longer eligible to participate in CPC+.

TRACK 2 PRACTICES ONLY: Missing Health IT Vendor MOU

Participating Track 2 practices are responsible for ensuring that their health IT vendor(s) sign an MOU with CMS. The Participation Agreement states the following in Section III.F.2(a):

> *"The CPC+ Practice acknowledges that as part of its application to participate in CPC+, it submitted a letter of support from each health IT vendor listed on the cover letter described in Section III.F.2(a) above. This letter expressed the health IT vendor's intention to sign a Memorandum of Understanding with CMS, outlining the health IT vendor's commitment to support the development of the required Track 2 enhanced health IT functions."*

CMS will reach out to the health IT vendor(s) indicated in the Vendor Letter(s) of Support that CPC+ practices provided in their applications and attempt to obtain a signed MOU. If the health IT vendor does not respond within 30 days, CMS will require Track 2 practices to procure a response and a signature from their health IT vendor(s). If a practice is unable to procure the response or MOU signature, the practice will be considered out of compliance with the CPC+ health IT requirements outlined in the Participation Agreement signed by the practice. CMS and the CPC+ Support will take the following actions:

1. Day 0: CPC+ Support will send a courtesy email to the practice notifying it that the health IT vendor has not responded to a request for a signed MOU, which is "day 0." The email will ask the practice to contact its health IT vendor(s) and inform the vendor that CMS requires the receipt of a signed MOU within 30 calendar days, or the practice will be at risk for termination from CPC+. Additionally, the practice will be asked to provide health IT vendor contact information if the contact(s) details on record are not accurate. The practice must acknowledge the receipt of the email within five business days.

   If the practice does not have a Vendor Letter of Support from the health IT vendor(s) that it plans to use to meet the advanced health IT requirements of CPC+, or if there is no Global Vendor Letter of Support on file for the vendor, the practice must obtain one from the vendor(s), and send the letter to CMS immediately via email at CPCPlus@Telligen.com.

   The practice should inform its health IT vendor(s) that the vendor(s) must sign the MOU as a follow-up to the Vendor Letter of Support. The health IT vendor will sign the MOU with CMS, and submit it to CPC+ Support. In the event that the health IT vendor declines to sign the MOU within 30 calendar days, the practice must identify a new health IT vendor(s), which must then provide a new Vendor Letter of Support and signed MOU.

2. Day 30: If no MOU is obtained for each of the Track 2 health IT vendors supporting the health IT requirements, CMS will issue a CPC+ Performance Alert to the practice. This notice will stipulate that the practice will have 90 calendar days to address the lack of Vendor Letter of Support and/or unsigned MOUs. Two options are available to these practices:

- Have existing health IT vendors submit the Vendor Letter of Support (if applicable) and sign the MOU; or
- Select and onboard a new health IT vendor(s), and submit signed Vendor Letters of Support and MOU.

3. Day 90: If the practice failed to secure a signed MOU after 90 days from the initial courtesy email, CMS will issue a Request for Corrective Action Plan. The practice will be asked to submit a Corrective Action Plan addressing the steps it plans to take to ensure compliance with CPC+ within 30 days from the letter's issuance. The Corrective Action Plan may include a freeze on CPC+ payments until the issue is resolved.

4. Day 120: If after 120 calendar days from the initial courtesy email, the practice fails to secure a signed MOU, CMS may remove the practice from CPC+. Once CMS terminates a practice, it is no longer eligible to participate in CPC+.

Appendix G. Getting CPC+ Practice Portal Access

Your application contact or your practice contact (as noted on your CPC+ application) must submit a list of individuals at the practice who will receive access to the CPC+ Practice Portal. Please submit your list to CPC+ Support by phone or email. We encourage you to ensure that multiple people at each practice site have CPC+ Practice Portal access. This access will allow your practice to complete requirements and access your CPC+ information even in the event of staff changes or unexpected absences. As CPC+ accounts cannot be shared, anyone who will access the CPC+ Practice Portal will need his or her own individual account. Immediately inform CPC+ Support if there are CPC+ Practice Portal user staffing changes to ensure only authorized access is granted.

For each CPC+ Practice Portal user at your practice, you must send CPC+ Support (cpcplus@telligen.com) the following information:

- First Name
- Last Name
- Email
- Phone
- Practice Role
- CPC+ Practice Site ID(s)
- CMS ePortal/EIDM User ID

Step 1: New User Registration for the CMS Enterprise Portal (ePortal)

1. Navigate to https://portal.cms.gov/.
2. Select **New User Registration** in the CMS ePortal box (see Figure 10).

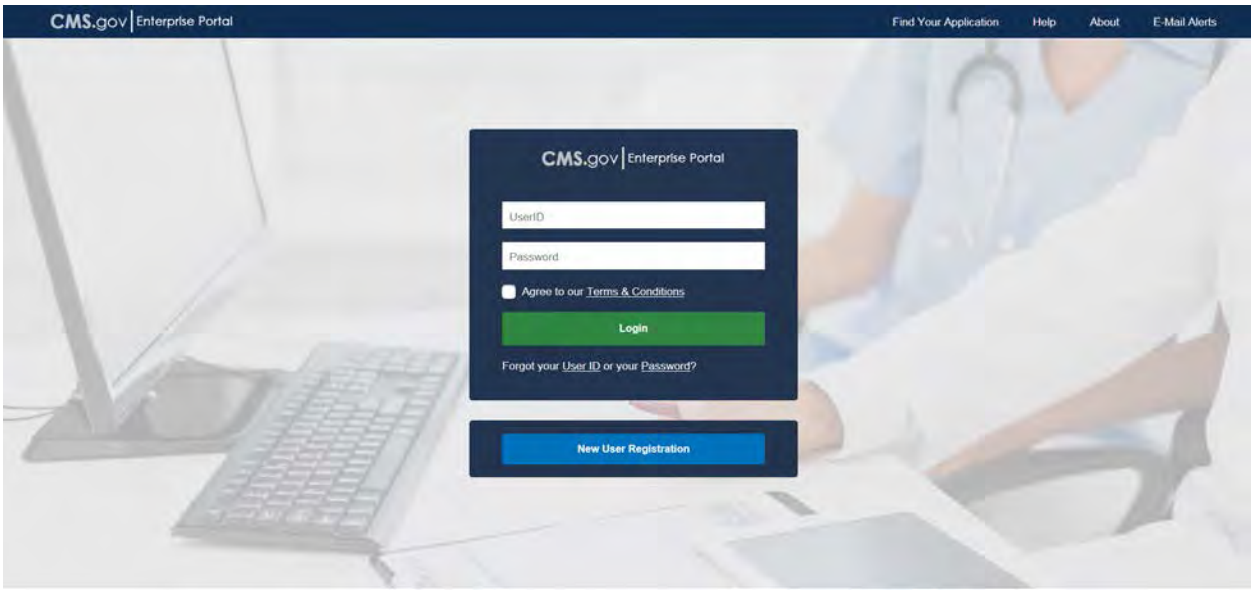


Figure 10: Portal Home – Begin Registration

3. Read the **Terms and Conditions**.
4. Select **I agree to the terms and conditions**.
5. Select **Next** (see Figure 11)**.**

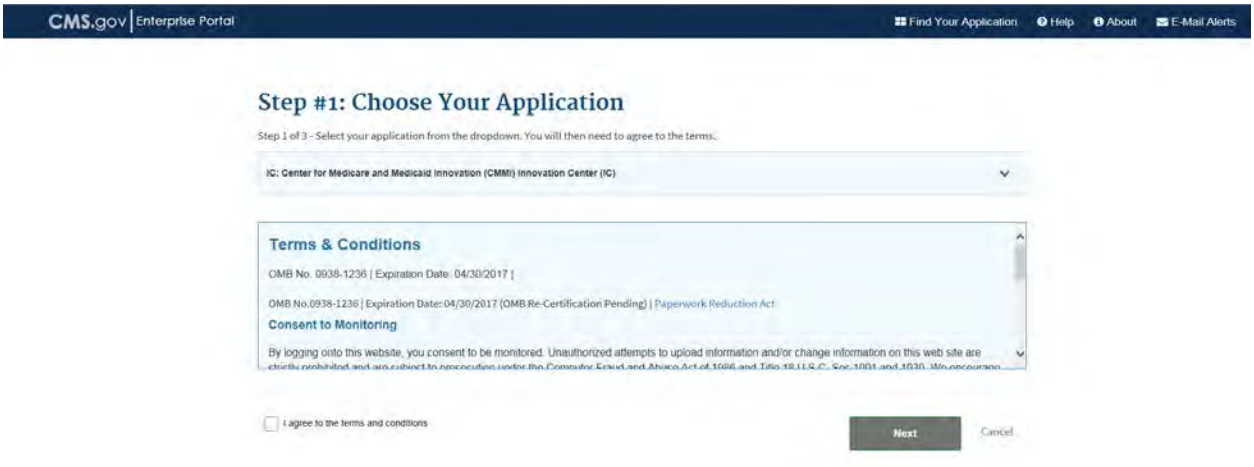


Figure 11: New Registration – Terms and Conditions

6. Complete the fields in the Register Your Information section.

   Note: Required fields are marked with an asterisk. Tool tips are provided for all fields. Please enter your Social Security number (SSN) if possible, while not required at this step, entering your SSN will limit the chance of complications during later registration steps.

7. Select **Next** once all fields are complete (see Figure 12).

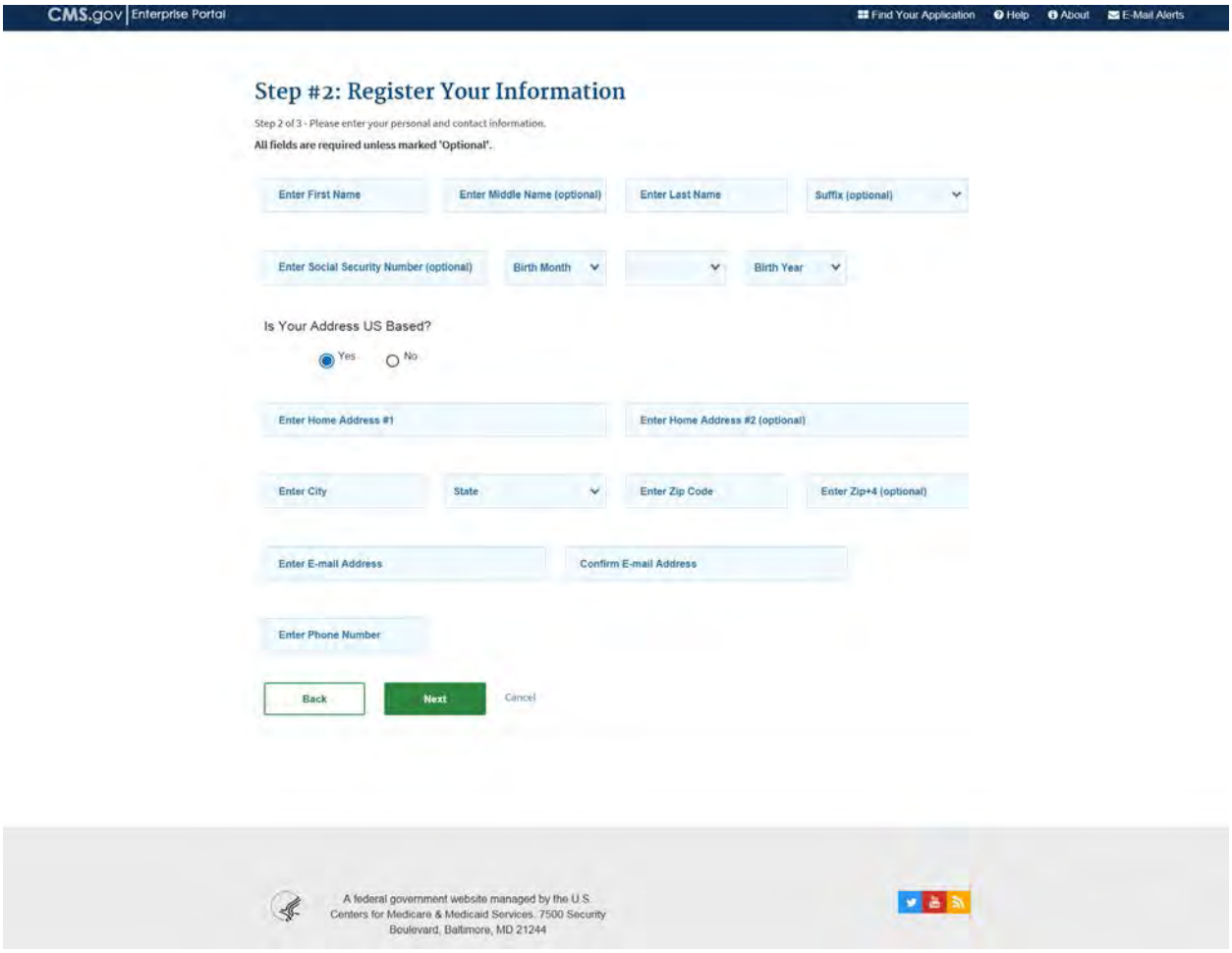


Figure 12: Register Your Information

8. Choose your User ID and Password.
9. Select and answer three challenge questions.

   Note: All fields are required and contain tool tips.

10. Select **Next** once all fields are complete (see Figure 13).

Figure 13: Choose User ID and Password and Challenge Questions

11. Once you have completed the required fields, you will be prompted with a Confirmation screen (see Figure 14).
12. Select **OK**.

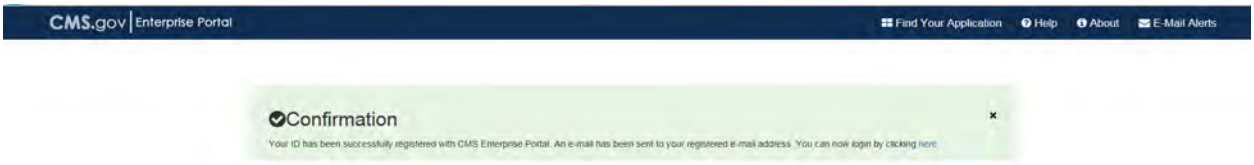


Figure 14: Confirmation

Step 2: Requesting Innovation Center Access

After you receive a user account for the CMS ePortal, you must request access to the Innovation Center application within the CMS ePortal (https://portal.cms.gov/).

1. Select **Login to CMS Secure Portal** (see Figure 15).

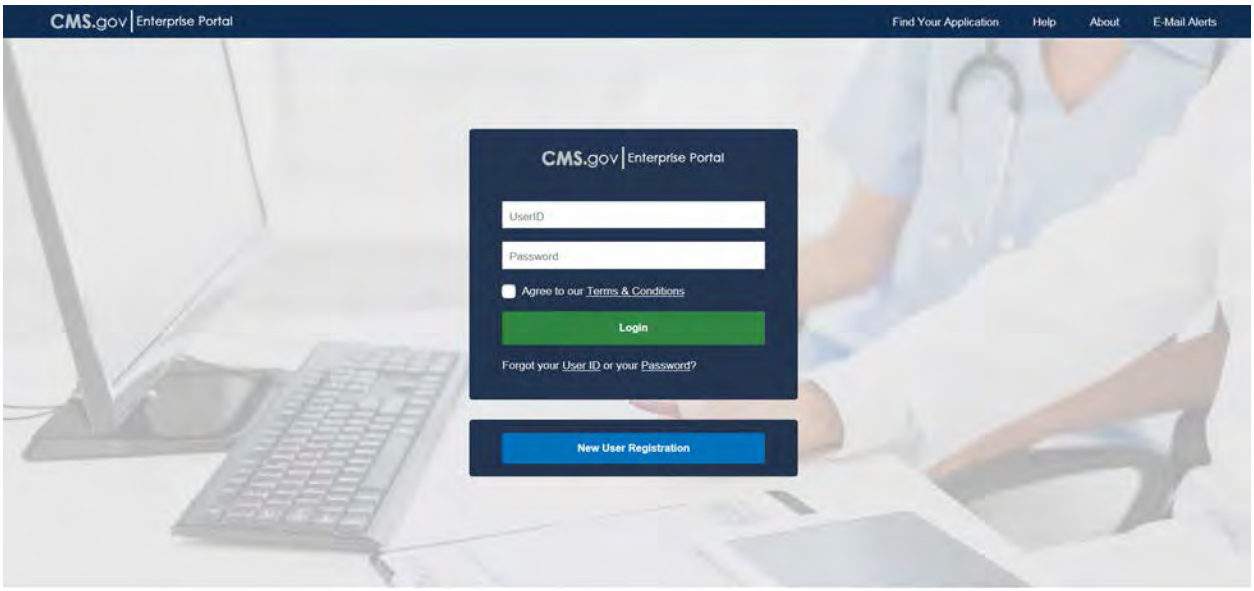


Figure 15: Portal Home – Log In

2. Enter your **User ID**.
3. Enter your existing **Password** information.
4. Select **Login**.
5. Select the **Agree to our…** checkbox.

   Note: After successful login, you will be directed to the My Portal main page.

6. Select **Request/Add Apps** (see Figure 16).

Figure 16: Request Access Now

7. Enter “IC” in the **Search** box and search.
8. Select **Request Access** (see Figure 17).

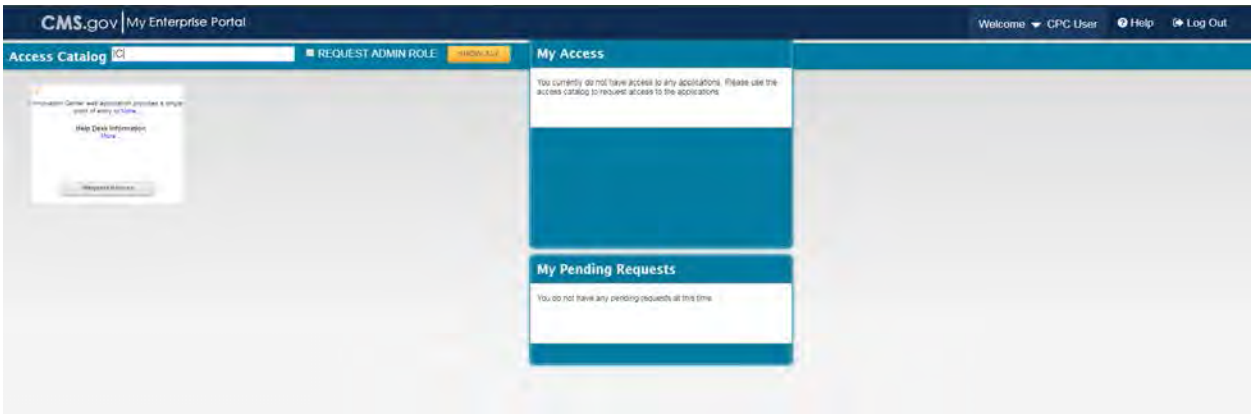


Figure 17: Access Catalog

Note: The Innovation Center system description will be pre-populated.

9. Select the **Innovation Center Privileged User** role from the drop-down list.

   Note: Only the Innovation Center Privileged User role will give the necessary rights to access the CPC+ Practice Portal.

10. Select **Submit** (see Figure 18).

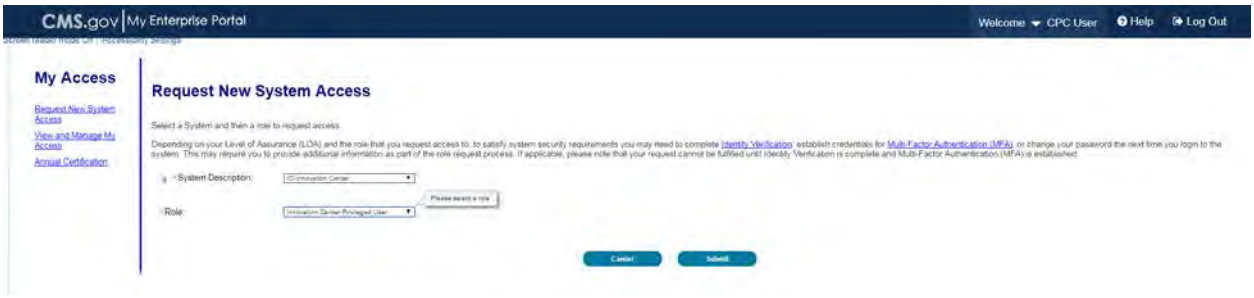


Figure 18: Request New System Access

11. Select **Next** to proceed to the Identity Verification page (see Figure 19).

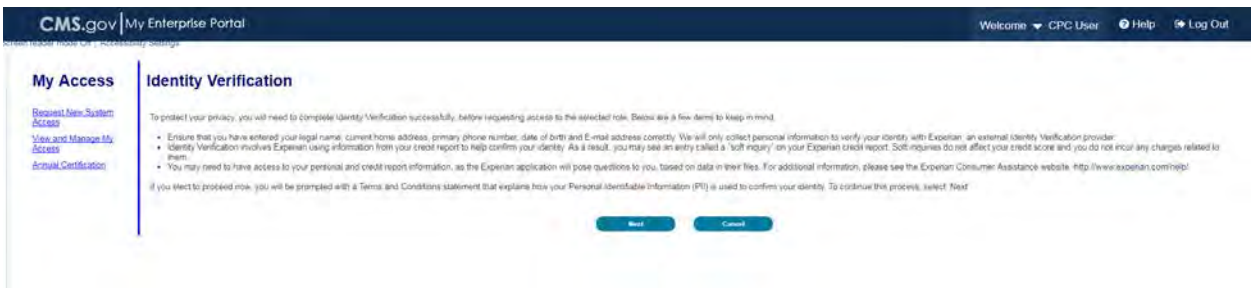


Figure 19: Identity Verification

12. Read the Terms and Conditions.
13. Select **I agree to the terms and conditions**.
14. Select **Next** (see Figure 20).

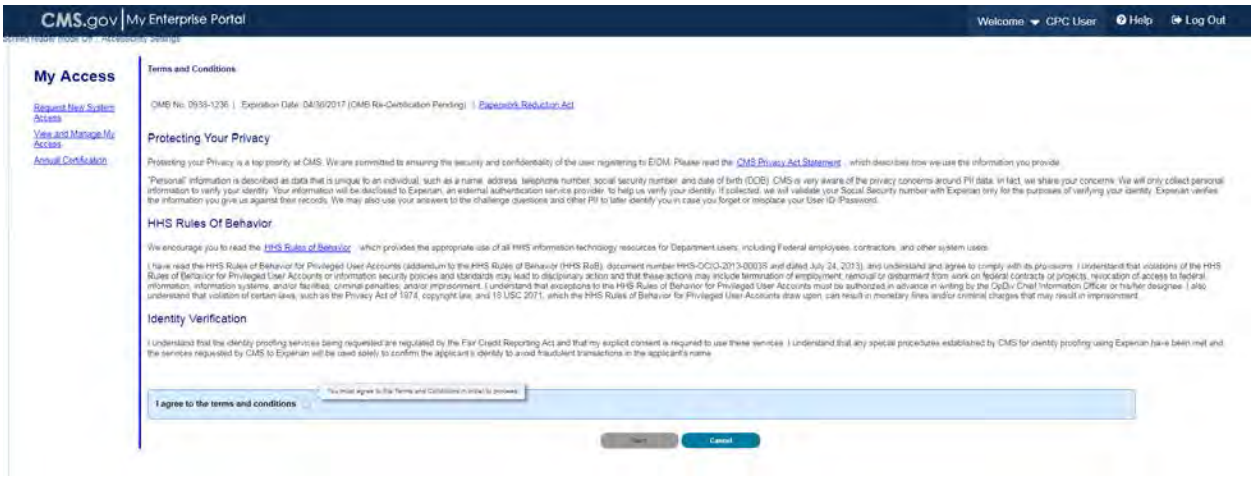


Figure 20: Terms and Conditions

15. Complete the required fields on the Your Information page (see Figure 21).

    Note: All fields are required (including **Social Security Number**), except for **Home Address Line 2** and **Zip Code Extension**.

16. Select **Next**.

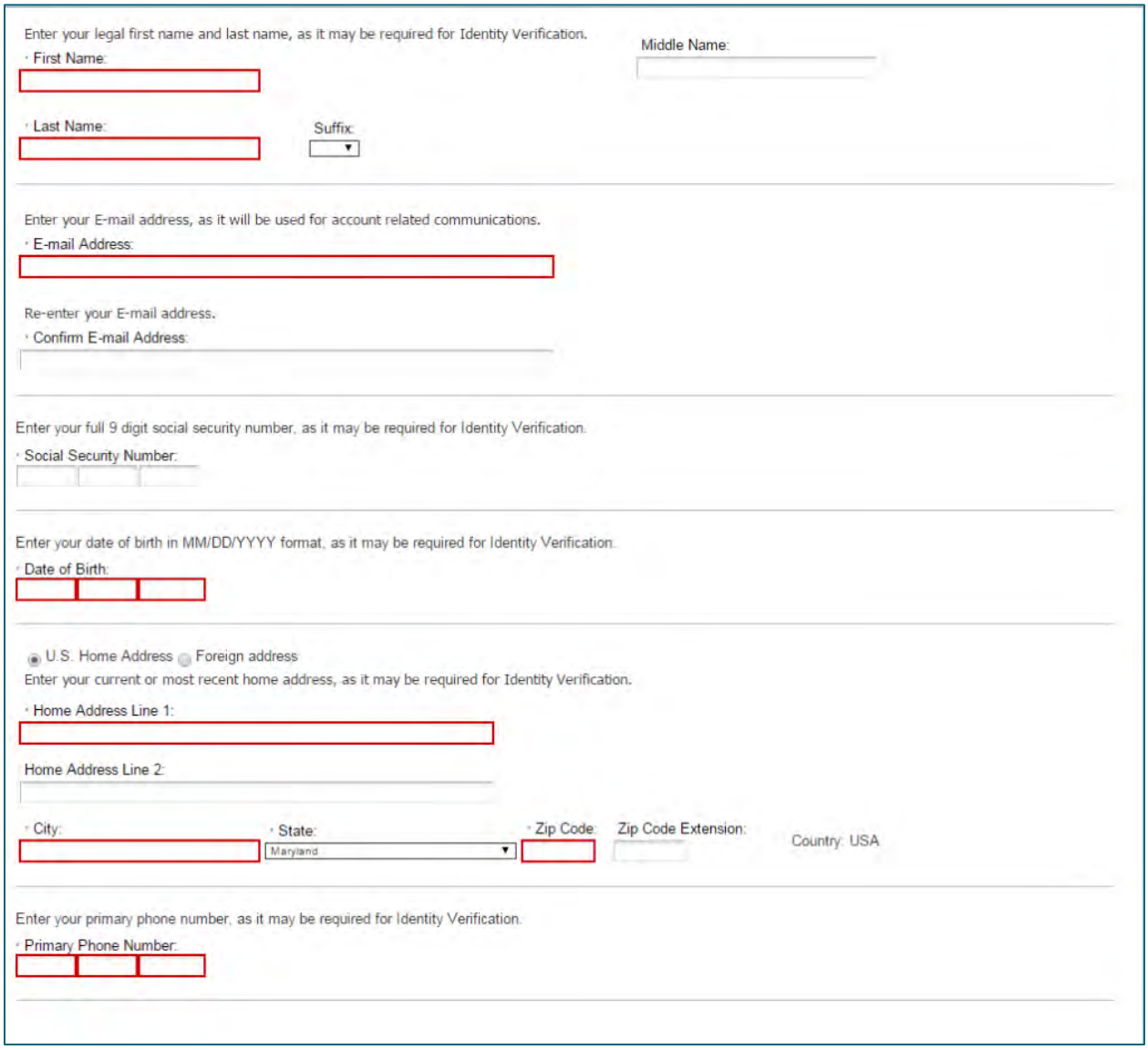


Figure 21: Your Information

17. Enter the required information on the Verify Identity page for the Remote Identity Proofing (RIDP) check (see Figure 22).
18. Select **Next**.

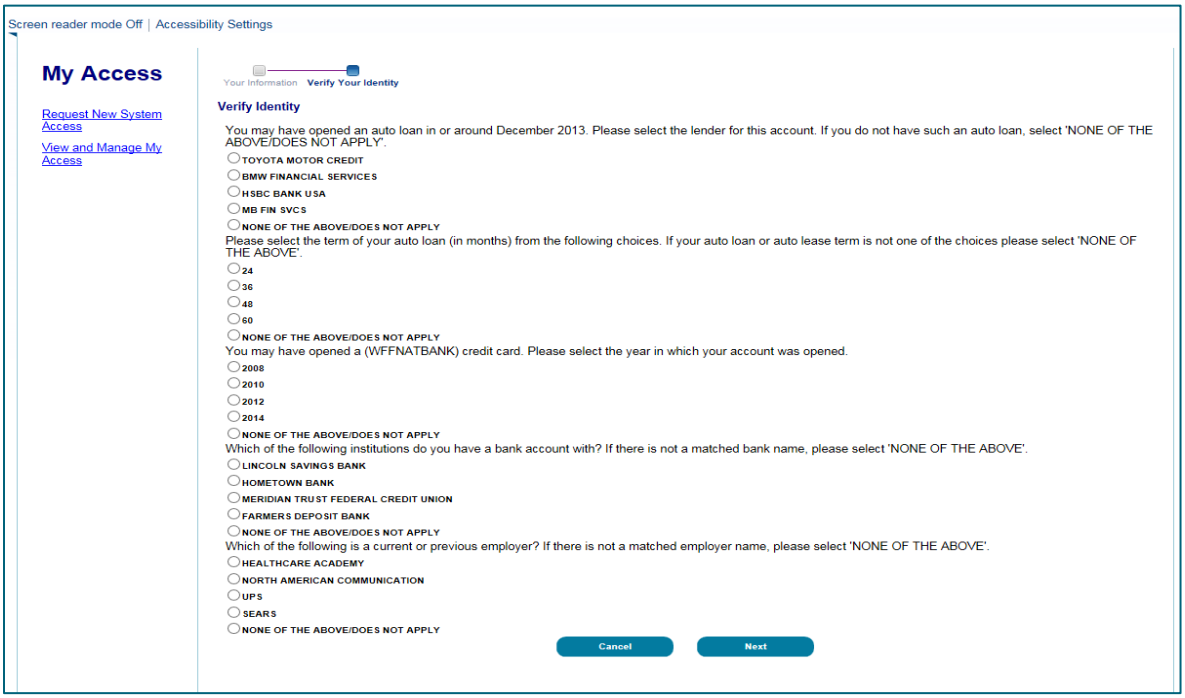


Figure 22: Verify Identity

Note: Upon successful completion of the Verify Identity page, you will be prompted with a success message.

19. Select **Next** (see Figure 23).

Figure 23: Complete Step Up

Note: After completing the RIDP process, you will be directed to the “Multi-Factor Authentication Information” page.

20. Select **Next** (see Figure 24).

Figure 24: MFA Information Confirmation

21. Register your phone, computer, or email for Multi-Factor Authentication Information. The Symantec software must be downloaded first if selecting the VIP option.

    Note: You will likely have to return to this page after downloading VIP Authentication Software.

22. Enter the credential ID and description once the software is downloaded and launched.

    Note: Description is a device nickname.

23. Select **Next** (see Figure 25).

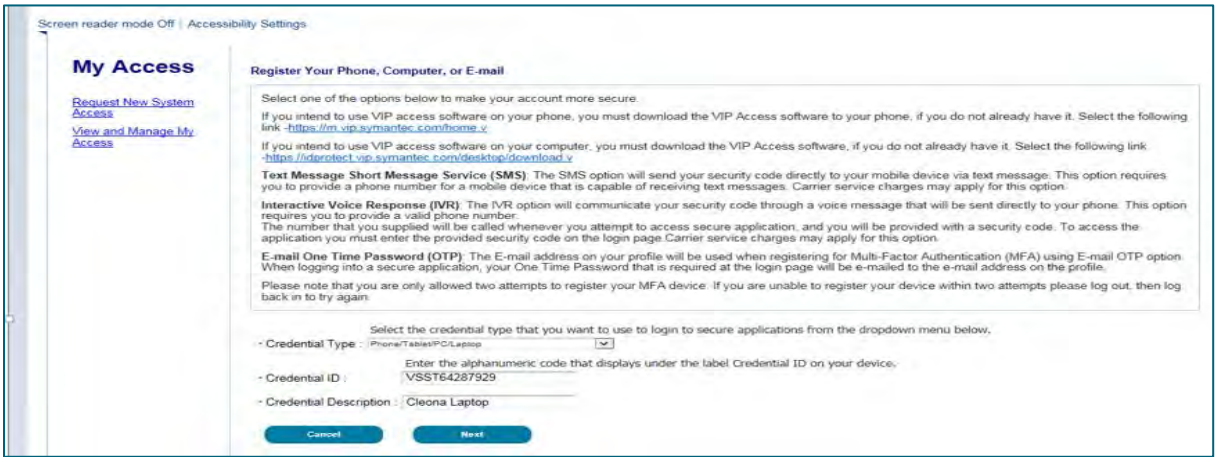


Figure 25: Secure Registration Screen

Note: Upon successful completion of the “Register Your Phone, Computer, or Email” page, you will be prompted with a success message.

24. Select **OK** (see Figure 26).

Figure 26: Secure Registration Confirmation

25. Select **OK** on the Request Acknowledgment screen to view your pending request (see Figure 27).

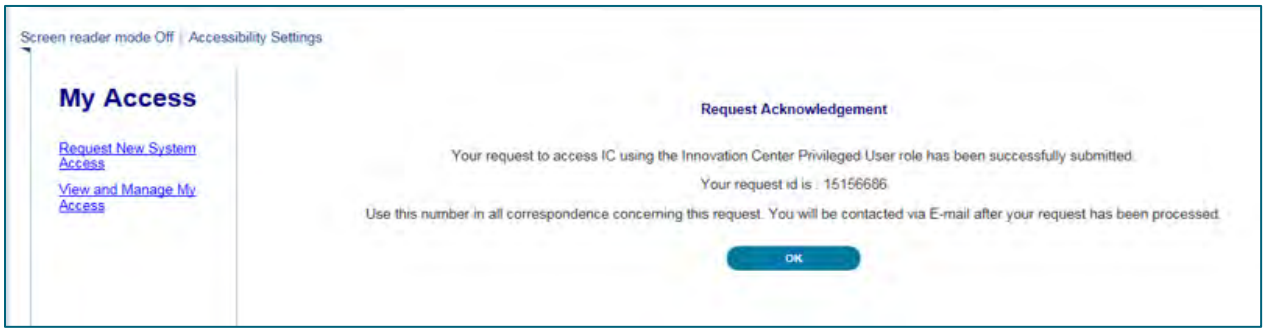


Figure 27: Request Acknowledgement

Once the request has been approved by the Innovation Center Application Approver, you will be informed via email. When you return to https://portal.cms.gov/ and log in, the Innovation Center will display as one of the menu options. From here you will be able to request access to the CPC+ Practice Portal.

Note: If logged in, you will need to log out and log back into portal.cms.gov for these new roles to take effect. After inputting your User ID, you will be prompted to provide a MFA code. The “Security Code” is a six-digit code tied to your MFA credential ID (Step 34). Select the appropriate “MFA Device Type” as available within the drop-down, then input the six-digit code. Each MFA six-digit code can only be used once per login, a new MFA code must be sent when logging into portal.cms.gov.

Step 3: Requesting Access to the CPC+ Practice Portal

Once you have successfully created a CMS ePortal account and have been approved for an IC Privileged User role, you must request access to launch the CPC+ Practice Portal. This request will be submitted from the CMMI Request Access page.

1. Select **Application Console** from the Innovation Center drop-down list (see Figure 28).

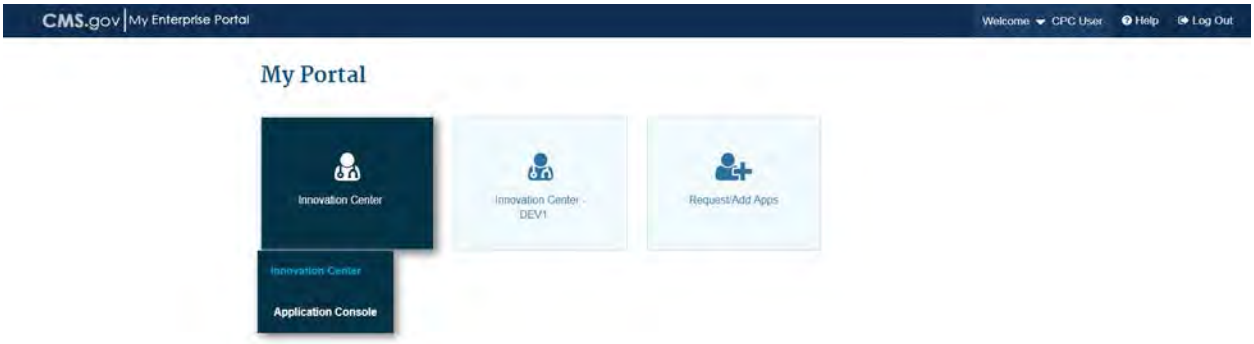


Figure 28: Portal After Log-in

2. Select **Request New Access** to put in a request (see Figure 29).

   Note: The Request Access section consists of a **Request New Access** button, a **Search** text field and button, and **Filter** buttons that allow the user to see the status of applications that have had requests submitted and are Pending, Approved, Rejected, or all.

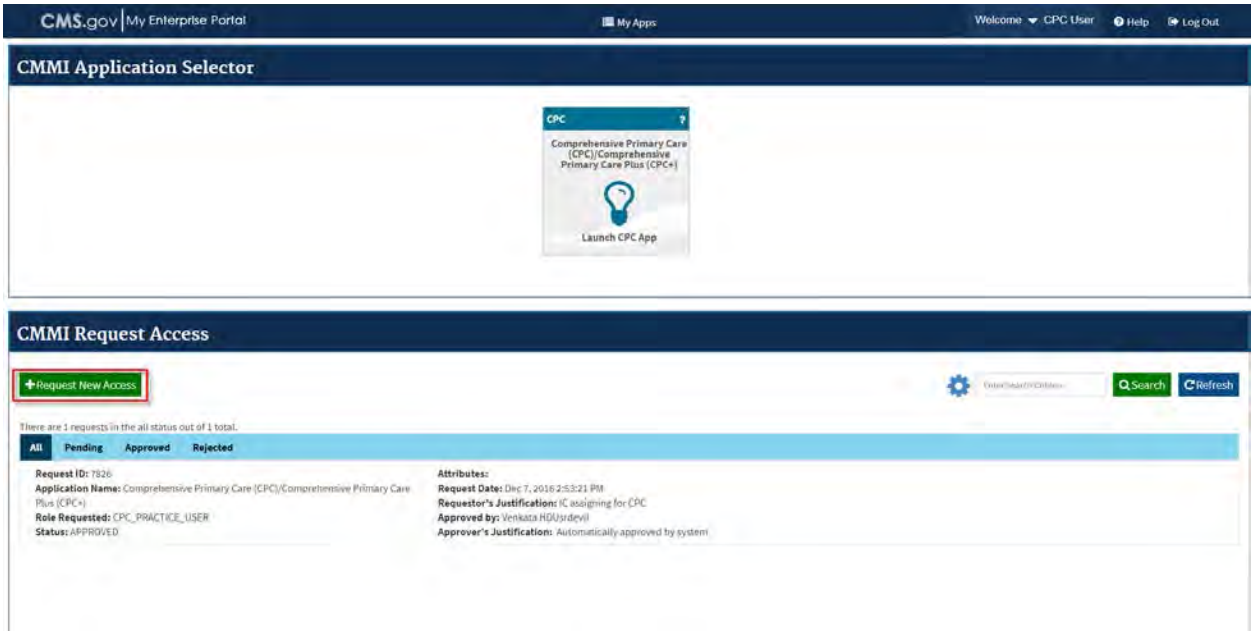


Figure 29: Request Access Screen

3. Upon selection of “Request New Access,” you will be prompted to complete a form requesting the Application Name, desired User Role, and Comments about your request (see Figure 30).

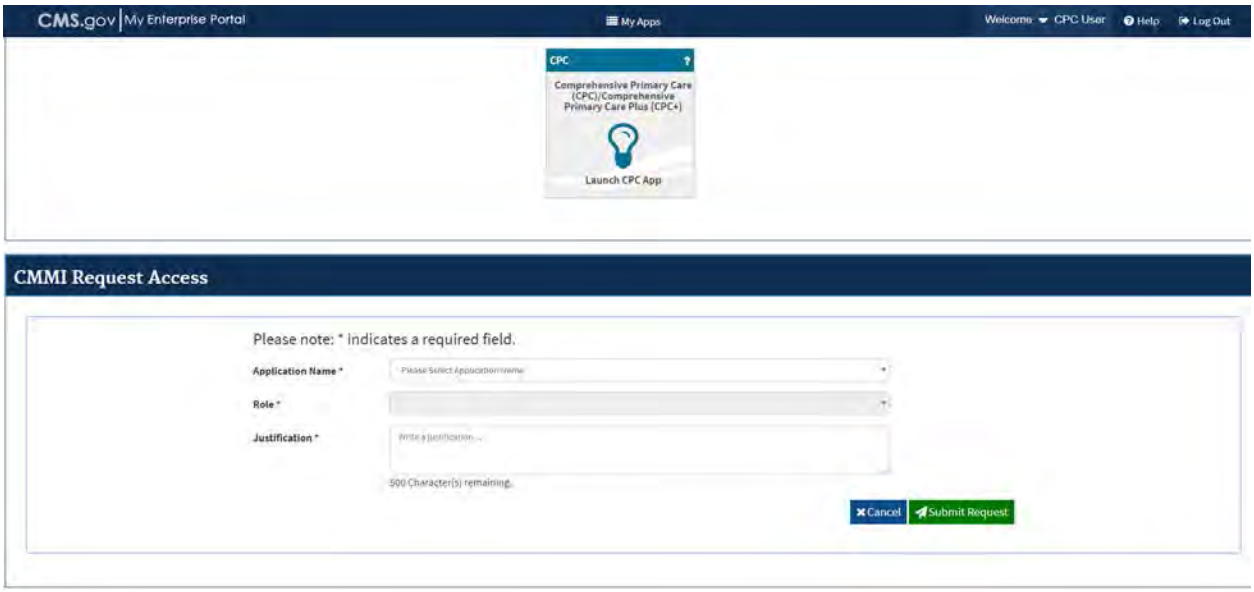


Figure 30: Application and Role Selection – Request Access Screen

4. Select Comprehensive Primary Care (CPC)/Comprehensive Primary Care Plus (CPC+) from the **Application Name** drop-down list (see Figure 31).

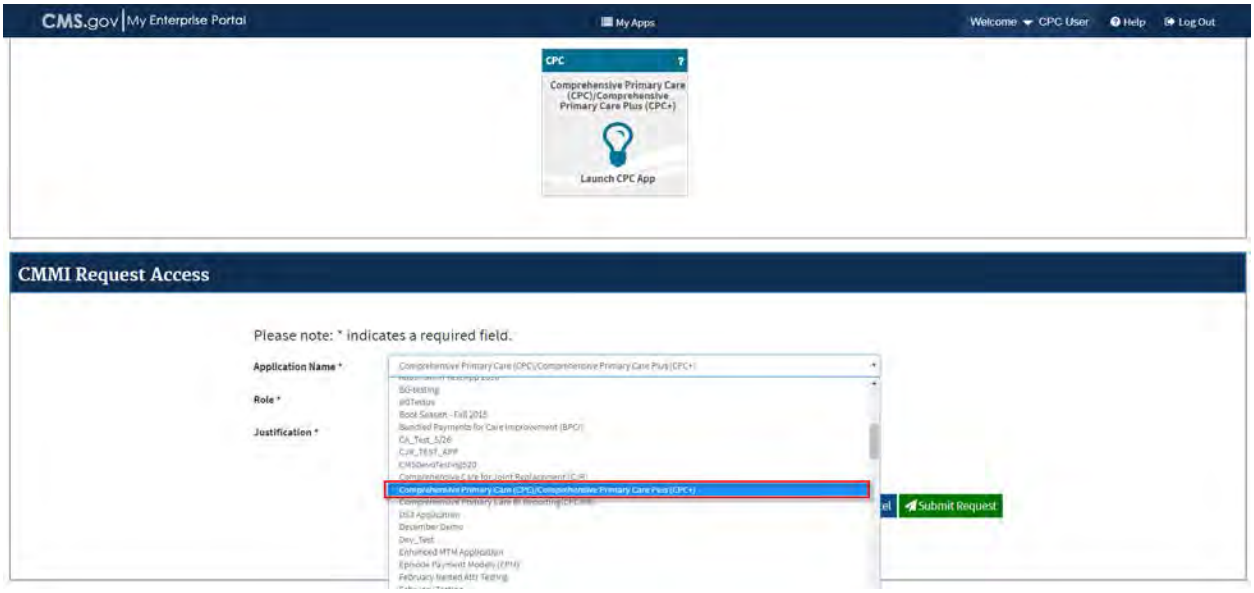


Figure 31: Application Name Selection – Request Access Screen

5. Select the appropriate User Role from the “User Role” drop-down list (see Figure 32).

   Note: Users who are accessing the CPC+ Practice Portal as a participating CPC+ practice must select **CPC_PRACTICE_USER**, regardless of their title at the practice, or the request will be rejected.

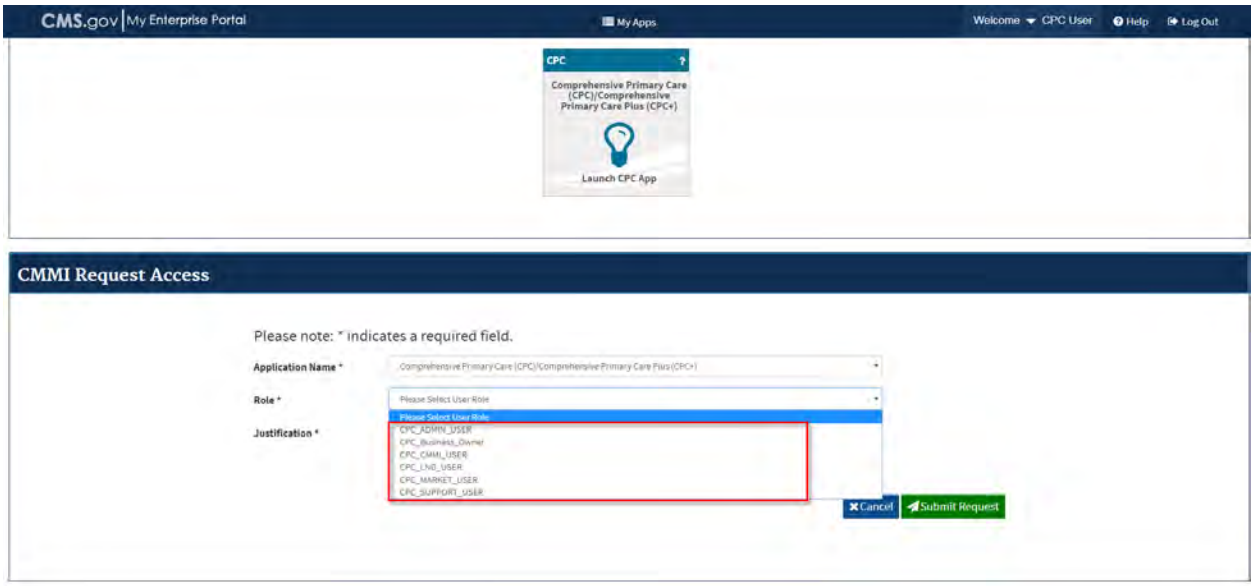


Figure 32: User Role Selection – Request Access Screen

Note: In the Justification section below the **Role** dropdown, all CPC+ practice users requesting access to the CPC+ Practice Portal must list all the CPC+ Practice IDs for which access is needed The CPC+ Practice ID is the 8-digit ID for your practice site, which contains a two-digit code for track, a two-digit code for region, and a four-letter numeric ID (e.g., T2OH9999). These requests will need to match what is listed on the approved user list provided by your CPC+ practice point of contact. If the information does not match the approved user list provided, the request will be rejected

6. Select **Submit Request** once all required fields are completed (see Figure 33).

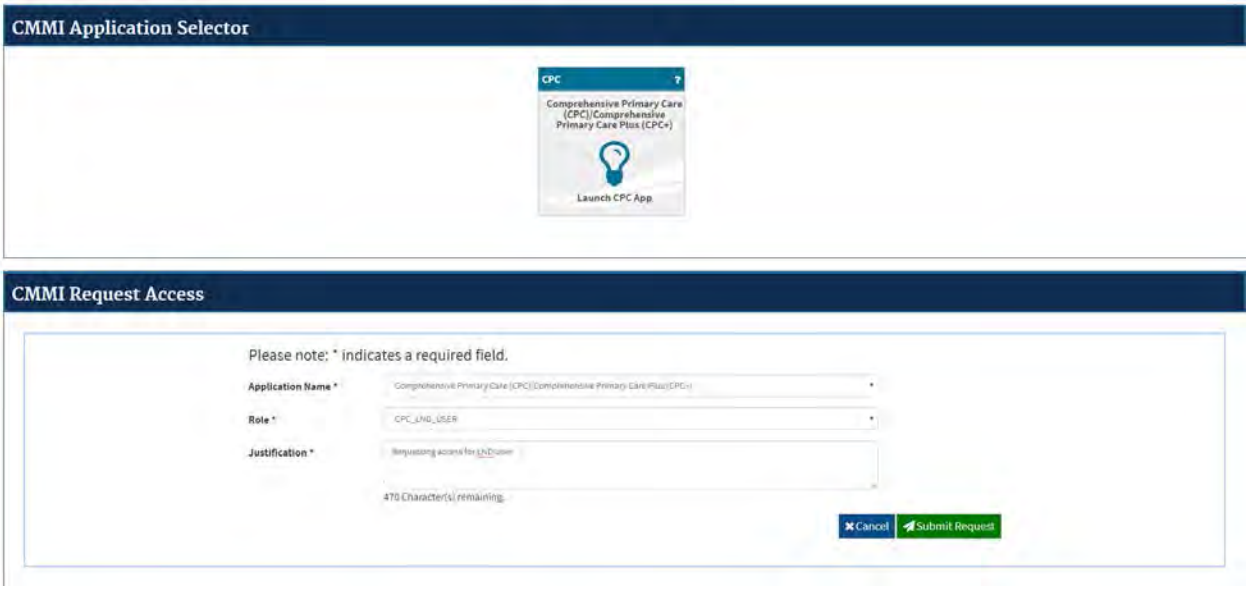


Figure 33: Application and Role Selection with Attribute Label – Request Access Screen

7. Once the CPC+ Web request has been submitted, you will return to the Request Access screen, where you will see the pending application request (see Figure 34).

Figure 34: Pending Request – Request Access Screen

Note: You will receive an email notification indicating that the request has been submitted. You will also receive an email notification when the request has been approved or rejected. If rejected, please review the instructions provided in the email received or contact CPC+ Support.

Step 4: Accessing the CPC+ Practice Portal

This section describes the process to log into the CPC+ Practice Portal.

1. Access https://portal.cms.gov/.
2. Select **Login to CMS Secure Portal** (see Figure 35).

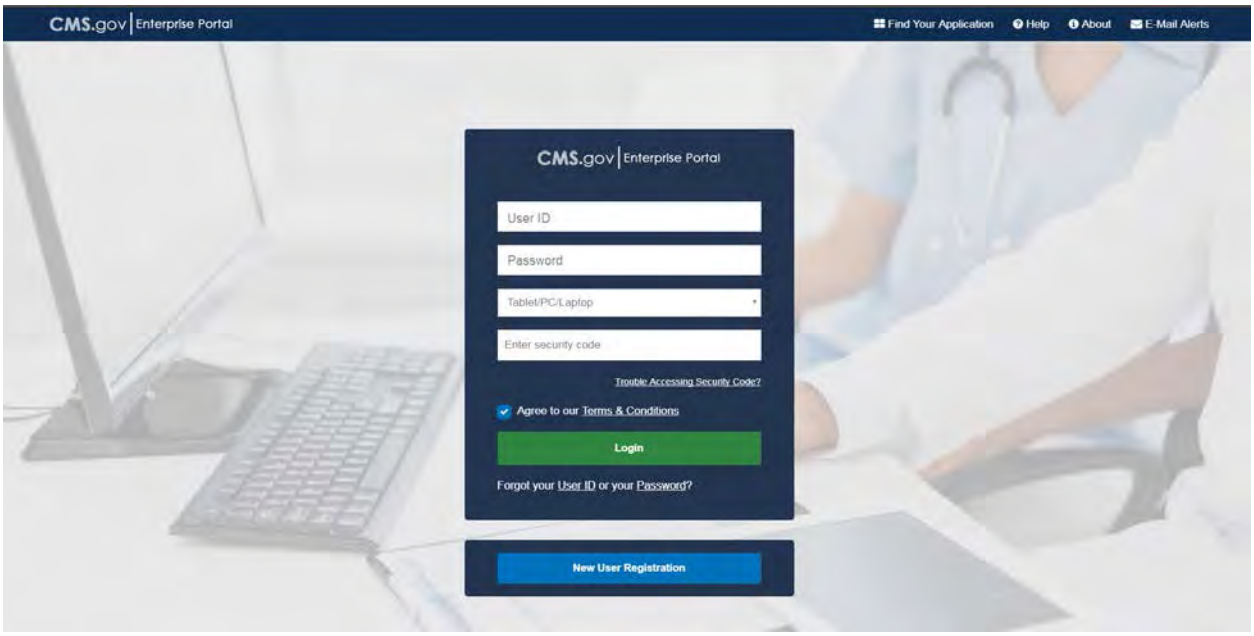


Figure 35: ePortal Home – Log In

Note: Upon successful ePortal log in, you will be directed to the CMS ePortal Home Page where Innovation Center will be one of your menu items at the top of the page (see Figure 36).

Figure 36: CMS Enterprise Portal Home

3. Select Application Console from the Innovation Center drop-down list (see Figure 37).

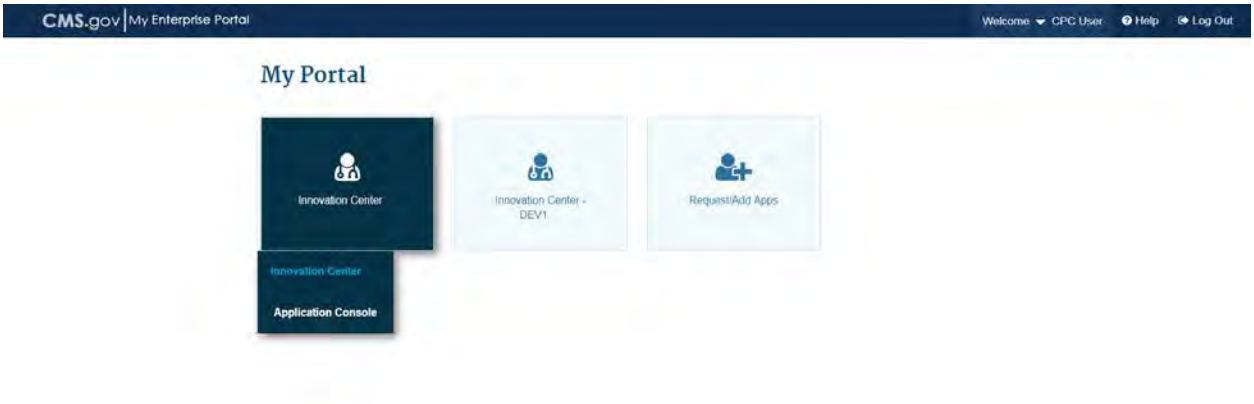


Figure 37: Innovation Center Menu

4. The Innovation Center landing page will display (see Figure 38).

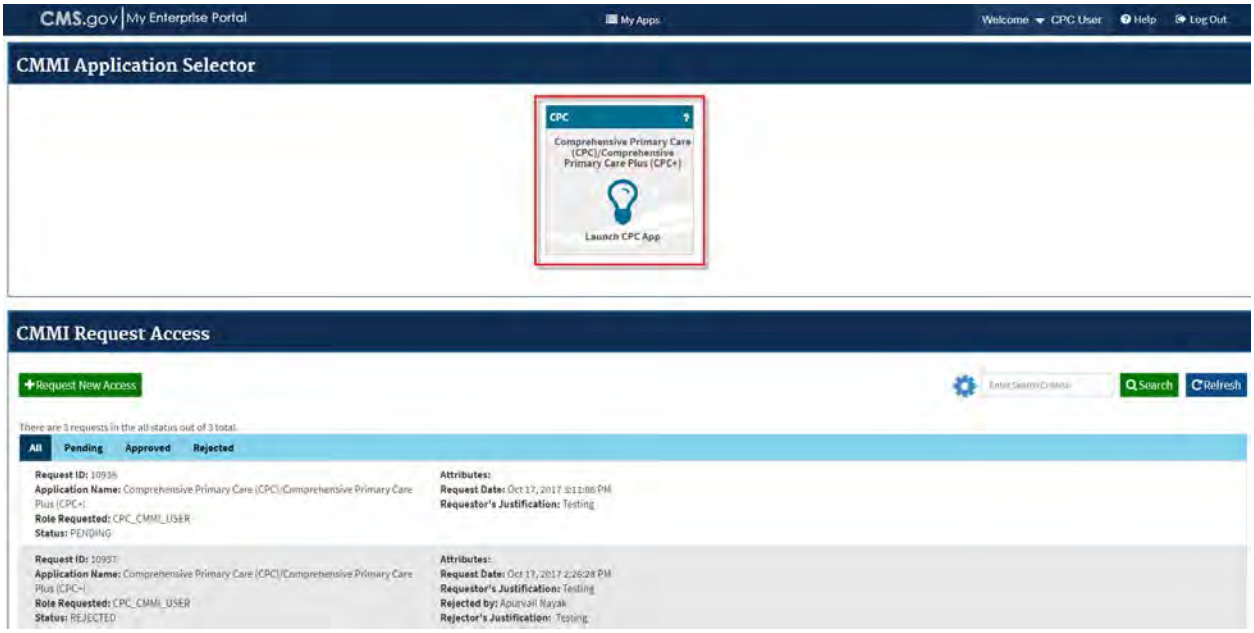


Figure 38: Launching the CPC+ Practice Portal

5. Select **Launch CPC App** to be directed to the CPC+ Practice Portal (see Figure 39).

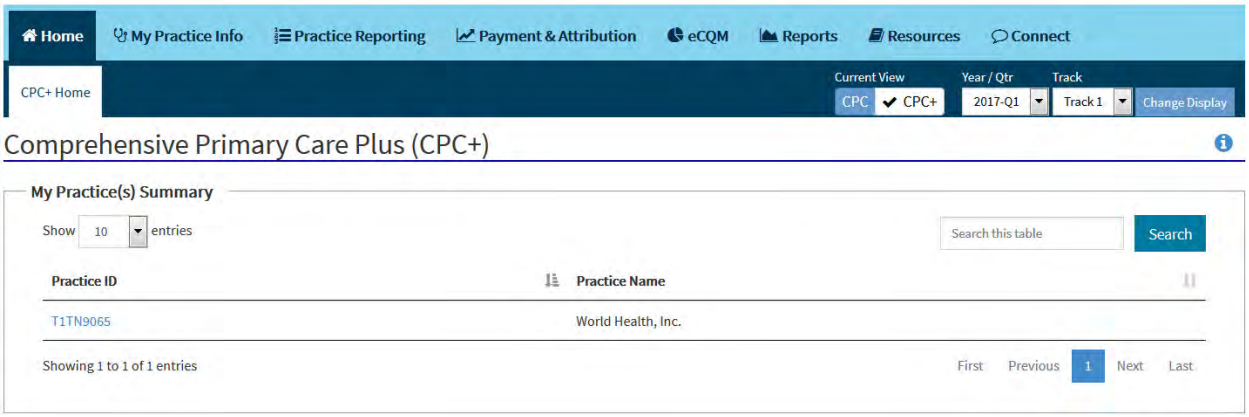


Figure 39: CPC+ Practice Portal Home

Note: You will need to launch the CPC App once every 60 days to avoid inactivity. If your account shows inactive for 60+ days your access will be removed and CPC+ Support will need re-approval from the Point of Contact for access to be restored.

Appendix H. Accessing CPC+ Connect

CPC+ Connect is a tool provided to CPC+ participants to share information and receive information about program participation and practice transformation. Access to CPC+ Connect is managed by the CMS Innovation Help Desk. Individuals at CPC+ practices wanting CPC+ Connect access must complete several steps in the correct order prior to access being granted.

Individuals must meet the following requirements in the order listed to obtain CPC+ Connect Access:

1. Be listed as a Primary, Secondary, Clinical Leader or Health IT contact, or be listed on the practitioner or staff roster in the CPC+ Practice Portal.
2. Request to be added to the CPC+ newsletter distribution list.
3. Request access to CPC+ Connect through self-registration or the CMMI Help Desk.

Step 1: Updating the CPC+ Practice Portal with Contact Information

1. Have your Primary Contact or the individual with CPC+ Practice Portal access navigate to https://portal.cms.gov/.
    a. Add the individual's contact information in the applicable area:
        i. Staff Roster
            1. The staff roster is located in the **Composition** tab of the My Practice Info page in the CPC+ Practice Portal.
                a. The staff roster should include:
                    i. Practice staff working at the physical site location directly involved with CPC+
                    ii. Administrative staff supporting the practice involved with CPC+ at an organizational level
                    iii. Non-practicing practitioners, or specialty practitioners who are not part of the practitioner roster, but who support the practice with CPC+ activities
                    iv. Consultants who work directly to support the practice with CPC+ activities
        ii. Practitioner Roster
            1. The practitioner roster is in the **Composition** tab of the My Practice Info page in the CPC+ Practice Portal.
                a. The practitioner roster displays the details of each practitioner associated with a practice.

i. This information is only displayed for attributed practitioners in CPC+.

iii. Primary, Secondary, Clinical Leader, and HIT Contacts are in the **Demographic Information** tab of the My Practice Info page.

1. **Main Contacts** within the practice

b. Click **Save** to save the changes made on each page.

Step 2: Contact CPC+ Support and Request To Be Added to the CPC+ On the Plus Side Newsletter Distribution List

1. Individuals wanting CPC+ Connect access must contact CPC+ Support via email at CPCplus@telligen.com or via phone at 1-888-372-3280.
    a. Request from CPC+ Support to be added to the CPC+ newsletter distribution list.
        i. Once this step has been completed, you will receive a notice informing you that you have been entered on the distribution list.

Step 3: Request CPC+ Connect Access

1. After completing Steps 1 and 2:
    a. Request CPC+ Connect access.
        ii. Self-register for your CPC+ Connect access here: https://app.innovation.cms.gov/CPCPlusConnect/CommunityRegistration

        OR

        iii. Contact the CMMI Help Desk at CMMIConnectHelpDesk@cms.hhs.gov or at 1-888-734-6433 and inform them that you need access to CPC+ Connect.

        iv. You will receive notification via email when your CPC+ Connect access request has been approved.

Appendix I. Updating Practice Information

Step 1: Updating Demographic Information

The Demographic Information page displays your practice's demographic information, points of contact, and health IT information. To edit these fields:

1. Select **Update Information**.
2. Make changes to desired fields.
3. Select **Save** (see Figure 40).

   Note: If you choose to enter Secondary Contact information, all fields in this section are required, unless otherwise noted.

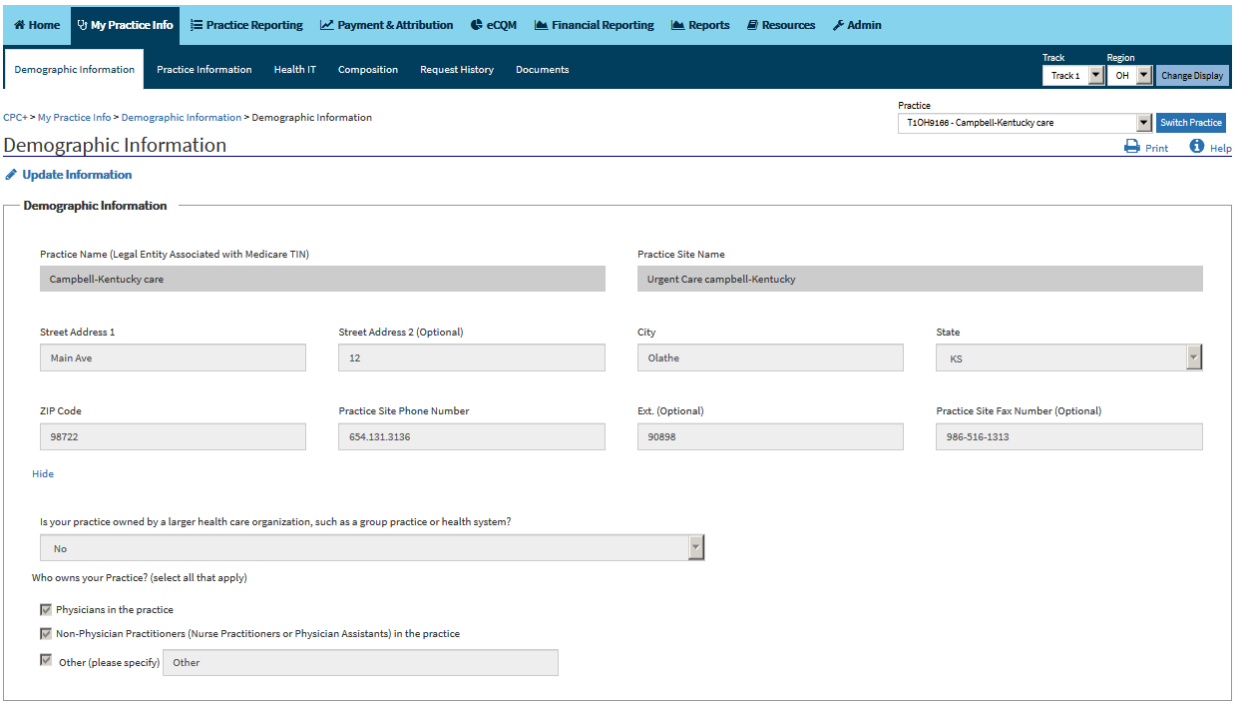


Figure 40: Demographic Information

Step 2: Updating Practice Information

The Practice Information page enables you to view your Health Information Technology Details and Organization Details (including TIN). This page is read-only by default.

If you want to edit these fields:

1. Select **Update Information.**
2. Make changes to desired fields.

3. Select **Save**.

If you want to initiate a TIN and/or an Organizational Detail Change:

1. Select **TIN/Org Change**.
2. The system navigates to the TIN/Organizational Change page.

Step 3: Updating TIN/Organizational Detail

The TIN/Organizational Change page displays the details necessary to request a TIN and/or an Organizational Detail Change for a practice (see Figure 41).

If you want to request a change:

1. Complete the **TIN/Organizational Details Change**.
2. Upload **Supporting Documentation**, if any. Refer to Section 3.4.3 of the *CPC+ Web Practice User Manual* for instructions on uploading a file.
3. Attest the accuracy of the information provided by completing the **Confirmation**.
4. Select **Save** to submit the request.

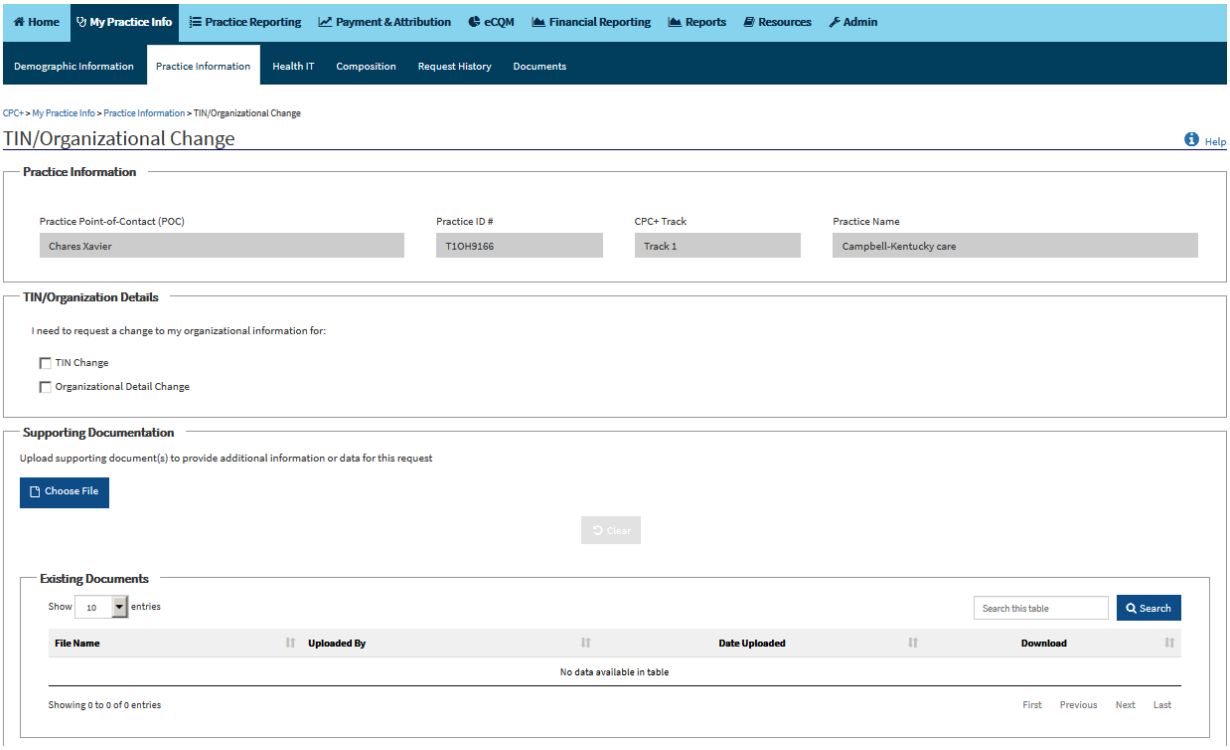


Figure 41: TIN/Organizational Change

Appendix J. Adding and Withdrawing Practitioners

Note: This appendix references the *CPC+ Web Practice User Manual*, which is available for download on the CPC+ Connect site. You can access the *CPC+ Web Practice User Manual* once you receive access to CPC+ Connect.

Step 1: Updating Rosters

The Composition page (see Figure 42) enables you to view and maintain your practice's practitioner and staff rosters. This information ensures the practices receive accurate care management fees (CMFs), performance-based incentive payments (PBIPs), and Comprehensive Primary Care Payments (CPCPs) (for Track 2 practices).

If you want to complete your practice's composition information:

1. Complete the fields on the Practice Composition page.
2. Verify **Practitioner Roster** and **Staff Roster** information.
3. Attest to the accuracy of the information provided by completing the **Confirmation.**
4. Select **Save.**

If you want to edit your practice's previously saved composition information:

1. Select **Update Information.**
2. Make changes to desired fields.
3. Verify **Practitioner Roster** and **Staff Roster** information.
4. Attest to the accuracy of the information provided by completing the **Confirmation.**
5. Select **Save.**

If you want to export your roster(s):

1. Select **Export Roster.**
2. Open or save the **PracticeID_ClinicianRoster** or **PracticeID_NonClinicianStaffRoster** in Excel file format.

   Note: The file should reflect the content from the respective roster's table.

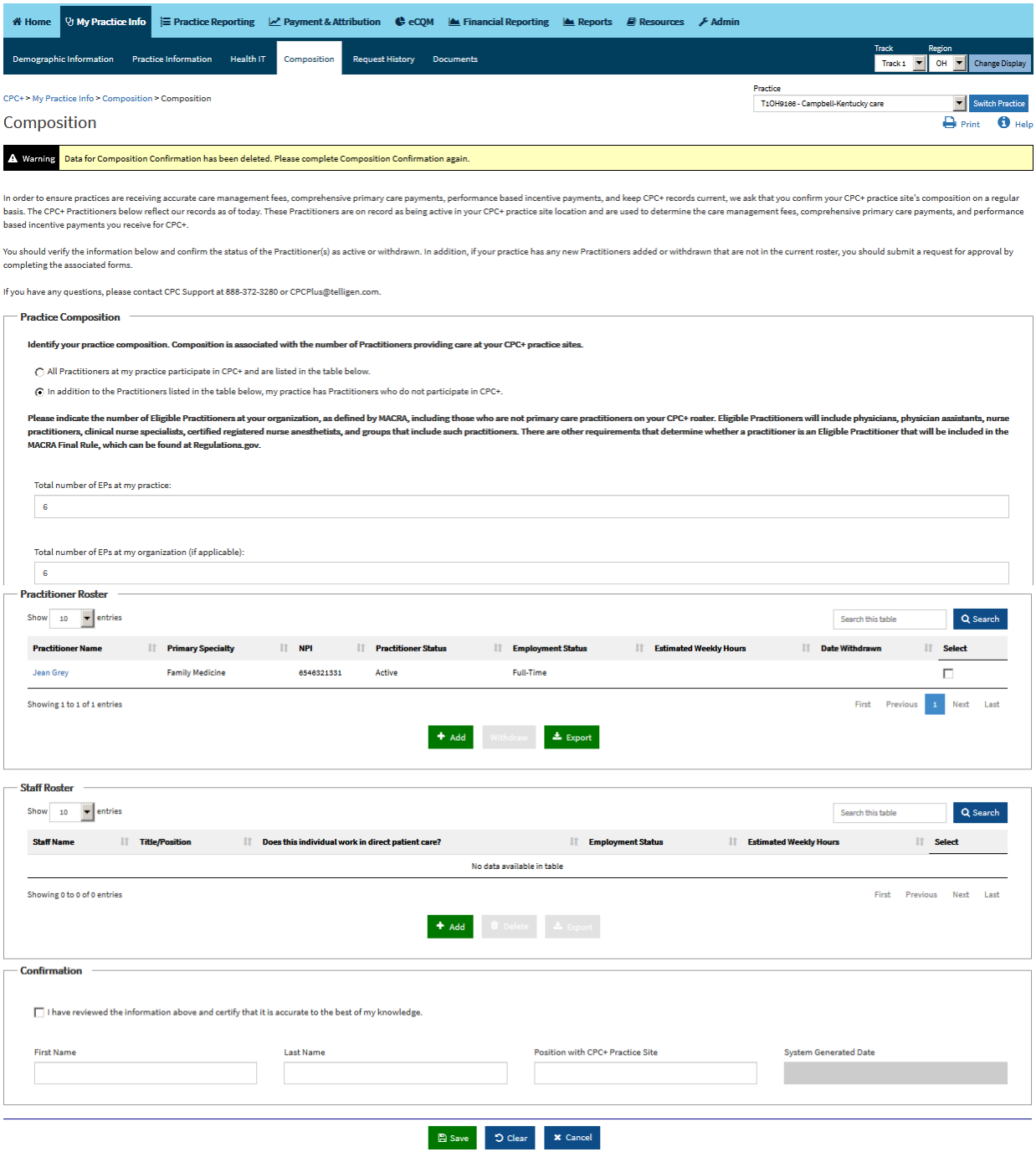


Figure 42: Practice Composition Page

1A Practitioner Roster

The Practitioner Roster displays the details of each practitioner associated with a practice, including the Practitioner Name, Primary Specialty, NPI, Status, Employment Status, and Estimated Weekly Hours.

Table 29 illustrates actions you can initiate from the Practitioner Roster section (see Figure 43: Practitioner Roster).

Table 29: Practitioner Roster Actions

If you want to…	Then…
Submit a request to add a New Practitioner	• Select **Add** from the Practitioner Roster. o Selecting **Add** will navigate you to the Add New Practitioner page. • Refer to the Add New Practitioner section for actions you can execute.
Submit a request to withdraw an Active Practitioner	• Select the check box in the far-right column of the table for the related practitioner. • Select **Withdraw**. o Selecting **Withdraw** will navigate you to the Withdraw Practitioner page. • Refer to the Withdraw Practitioner section for actions you can execute.
View Practitioner Information for a practitioner in Active or Withdrawn status	• Select the related **Practitioner Name**. o Selecting the **Practitioner Name** will navigate you to the Practitioner Information page. • Refer to the Practitioner Information section for actions you can execute.
Edit Practitioner Information for Practitioner in Active status	• Select the related **Practitioner Name**. o Selecting the **Practitioner Name** will navigate you to the Practitioner Information page. • Refer to the Practitioner Information section for actions you can execute.
View request details or add remark to a request in Pending Add, Pending Withdraw, Incomplete Add, or Incomplete Withdraw status	• Select the related **Practitioner Name**. o Selecting the **Practitioner Name** will navigate you to the Add New Practitioner Request or Withdraw Practitioner Request page. • Refer to the Add New Practitioner and Withdraw Practitioner sections for actions you can execute.
Edit request details for a practitioner in Incomplete Add or Incomplete Withdraw status	• Select the related **Practitioner Name**. o Selecting the **Practitioner Name** will navigate you to the Add New Practitioner Request or Withdraw Practitioner Request page. • Refer to the Add New Practitioner and Withdraw Practitioner sections for actions you can execute.

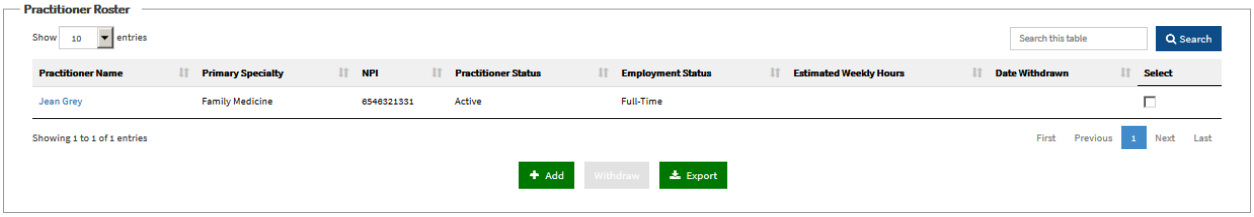


Figure 43: Practitioner Roster

1B Staff Roster

The staff roster displays details on the staff associated with your CPC+ practice. These details include: Staff Name and Title/Position, if the individual works in direct patient care, Employment Status, and Estimated Weekly Hours. The staff roster should contain any and all staff who actively support the CPC+ program, but are not listed on the practitioner roster or as a contact on the Practice Demographics page. The staff roster must include at least one staff member who is physically located at the practice site.

The staff roster should include any of the following staff members who directly support your practice's CPC+ activities:

- Practice staff working at the physical site location directly involved with CPC+
  - The staff roster must include at least one staff member who is physically located at the practice site.
- Administrative staff supporting the practice involved with CPC+ at an organizational level
- Non-practicing practitioners, or specialty practitioners who are not part of the practitioner roster, but support the practice with CPC+ activities

Please note that the staff roster is separate from the practitioner roster. The staff roster should not include active CPC+ practitioners. Some practices may have non-practicing practitioners serving in a staff role. For example, a practice may have a clinic director supporting CPC+ who is also a medical doctor, but does not see patients. In this case, the practitioner would not be included in the practitioner roster, but would instead be included in the staff roster.

- Consultants who work directly to support the practice with CPC+ activities
  - Some practices may want to include a consultant on their staff roster. In these cases, your practice is considered a "sponsor" for that consultant. This includes providing management and oversight with respect to the data the consultant has access to, and how he or she uses that information. Your practice is responsible for ensuring staff, including consultants, on the staff roster are not selling or otherwise distributing data in a way that is not directly related to supporting your practice's CPC+ activities.

In some cases, an individual may be supporting many CPC+ practices. In these cases, the individual must be present on the staff roster for each practice that he or she supports.

Table 30 illustrates actions you can initiate in the Non-Clinician Staff Roster section of the **Composition** tab (see Figure 44).

Table 30: Staff Roster Actions

If You Want To …	Then …
View Staff Information	• Select **Staff Name**. • Selecting the **Staff Name** will navigate you to the Staff Information page. • Refer to the Updating Staff Information section for actions you can execute.
Edit Staff Information	• Select **Staff Name**. • Selecting the **Staff Name** will navigate you to the Staff Information page. • Refer to the Updating Staff Information section for actions you can execute.
Add a New Staff member	• Select **Add**. • Selecting **Add** will navigate you to the Add New Staff page. • Refer to the Updating Staff Roster section for actions you can execute.
Delete an existing Staff member	• Select the box displayed beside the **Estimated Weekly Hours**. • Select **Delete**. • Select **Yes** on the **Confirm Staff Deletion** pop-up.

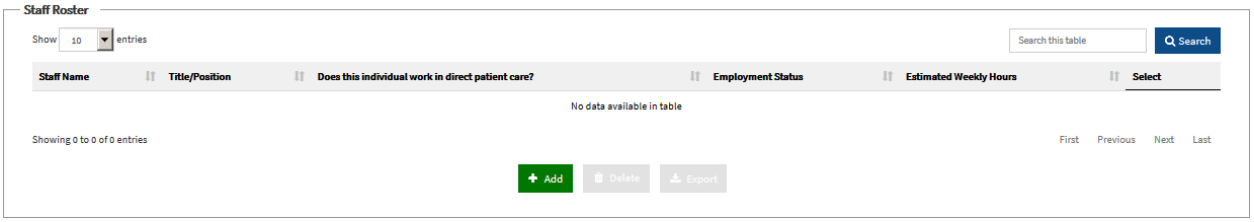


Figure 44: Staff Roster

Step 2: Adding a New Practitioner

The Add New Practitioner page displays the details necessary to request to add a new practitioner (see Figure 45).

If you want to submit an Add New Practitioner request:

1. Complete the **Practitioner Details**.
2. Upload **Supporting Documentation**, if any.
3. Attest the accuracy of the information provided by completing the **Confirmation**.

4. Please note the acceptable Primary Care Specialty Codes for physicians:
    - Family Medicine—207Q00000X
    - Adult Medicine—207QA0505X
    - Geriatric Medicine—207QG0300X
    - Hospice and Palliative Medicine—207QH0002X
    - General Practice—208D00000X
    - Internal Medicine—207R00000X
    - Geriatric Medicine—207RG0300X
    - Hospice and Palliative Medicine—207RH0002X
5. Select **Save** to submit the request.

If you want to add a remark to an Add New Practitioner Request in Pending status:

1. Add a **Remark**, if applicable. Refer to Section 3.4.4 of the *CPC+ Web Practice User Manual* for instructions on adding a remark.
2. Select **Save**.

If you want to edit an Add New Practitioner Request in Incomplete status:

1. Select **Update Information**.
2. Make desired changes.
3. Upload **Supporting Documentation**, if any. Refer to Section 3.4.3 of the *CPC+ Web Practice User Manual* for instructions on uploading a file.
4. Add a **Remark**, if applicable. Refer to Section 3.4.4 of the *CPC+ Web Practice User Manual* for instructions on adding remarks.
5. Attest the accuracy of the information provided by completing the **Confirmation**.
6. Select **Save**.

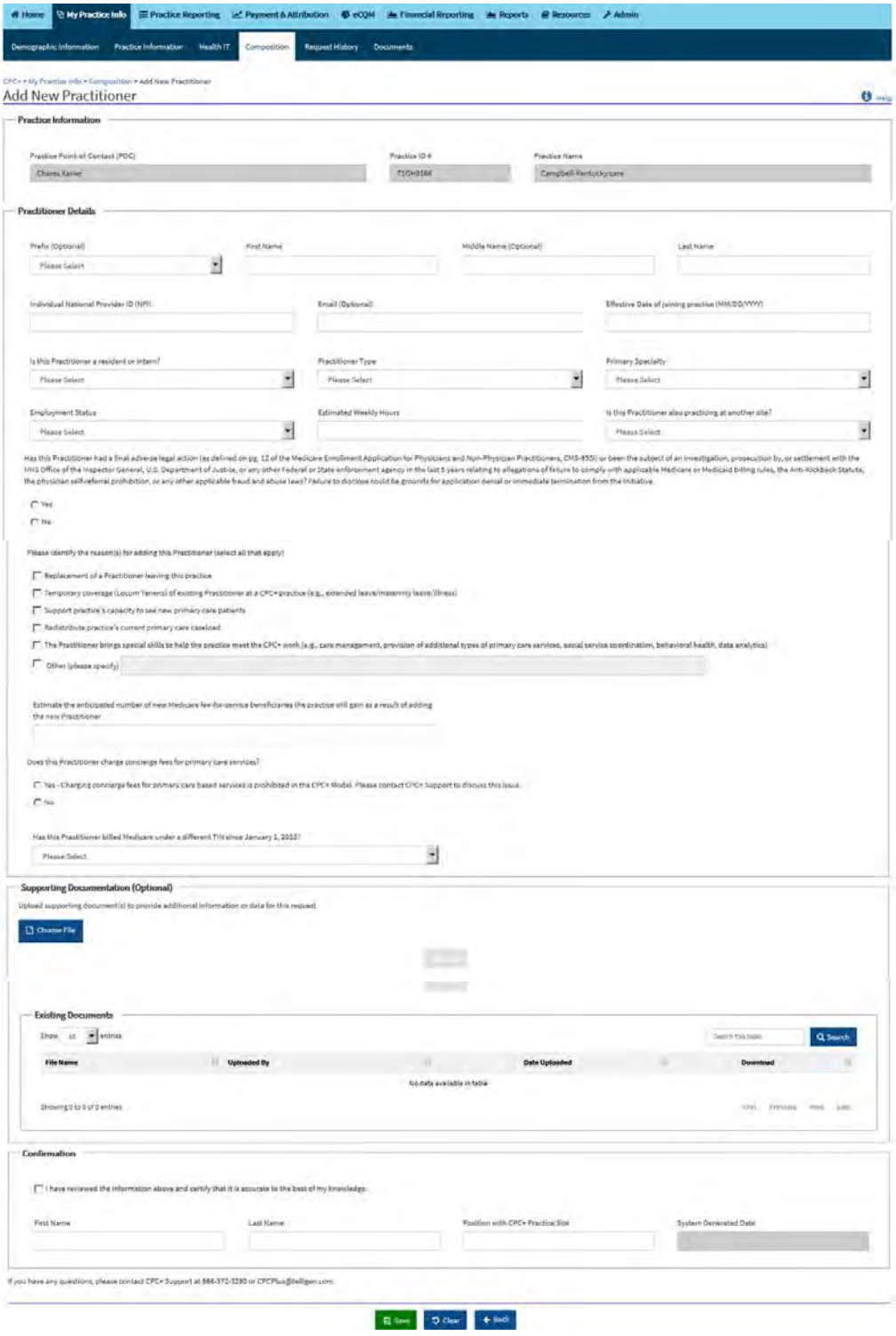


Figure 45: Add New Practitioner

Step 3: Updating Practitioner Information

The Information page displays the details for an Active or Withdrawn Practitioner (see Figure 46).

If you want to edit Practitioner Information for an Active Practitioner:

1. Select **Update Information**.
2. Make the desired changes.
3. Select **Save**.

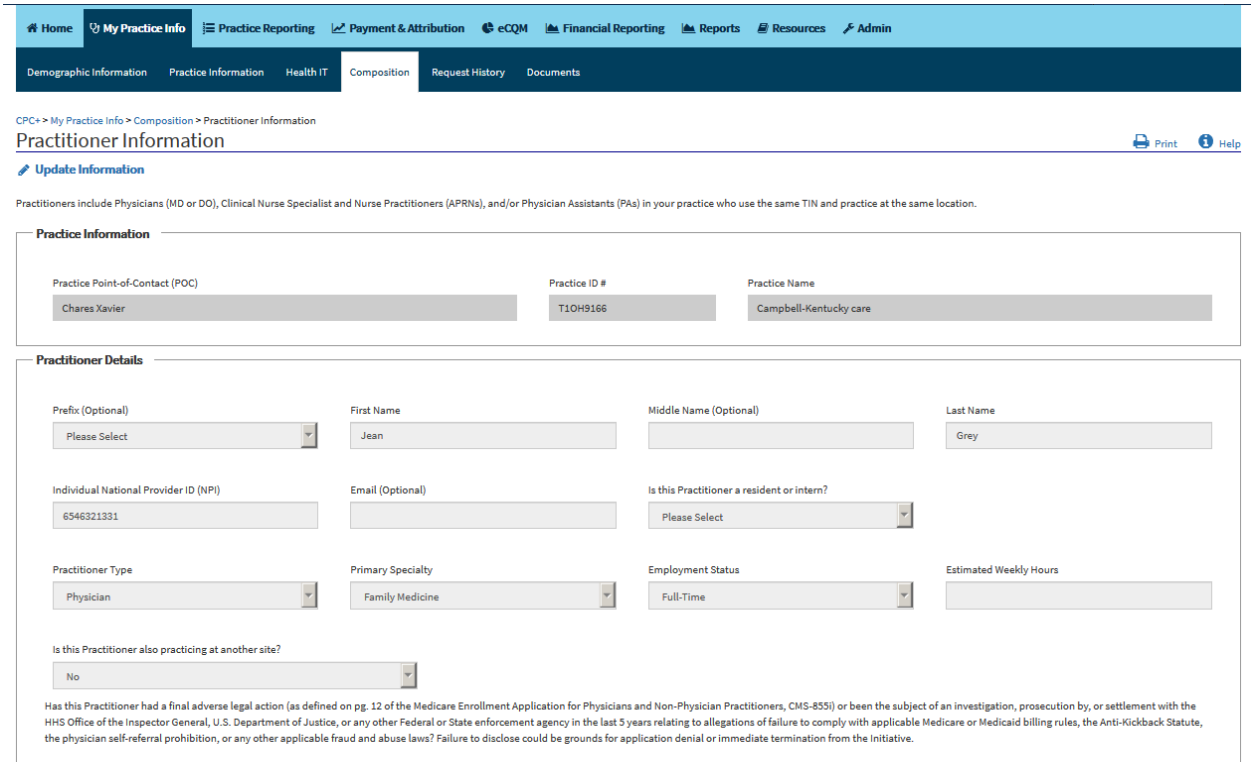


Figure 46: Practitioner Information

Step 4: Withdrawing a Practitioner

The Withdraw Practitioner page displays request details necessary for withdrawing an existing Active Practitioner from your practice (see Figure 47).

If you want to submit a Withdraw Practitioner Request:

1. Complete the **Withdrawal Information**.
2. Upload **Supporting Documentation**, if any. Refer to Section 3.4.3 of the *CPC+ Web Practice User Manual* for instructions on uploading a file.

3. Attest the accuracy of the information provided by completing the **Confirmation**.
4. Select **Save** to submit the request.

If you want to add a remark to a Withdraw Practitioner Request in Pending status:

1. Add a **Remark**, if applicable. Refer to Section 3.4.4 of the *CPC+ Web Practice User Manual* for instructions on adding a remark.
2. Select **Save**.

If you want to edit a Withdraw Practitioner Request in Incomplete status:

1. Select **Update Information**.
2. Make desired changes to **Withdrawal Information**.
3. Upload **Supporting Documentation**, if any. Refer to Section 3.4.3 of the *CPC+ Web Practice User Manual* for instructions on uploading a file.
4. Add a Remark, if applicable. Refer to Section 3.4.4 of the *CPC+ Web Practice User Manual* for instructions on adding a remark.
5. Attest the accuracy of the information provided by completing the **Confirmation**.
6. Select **Save**.

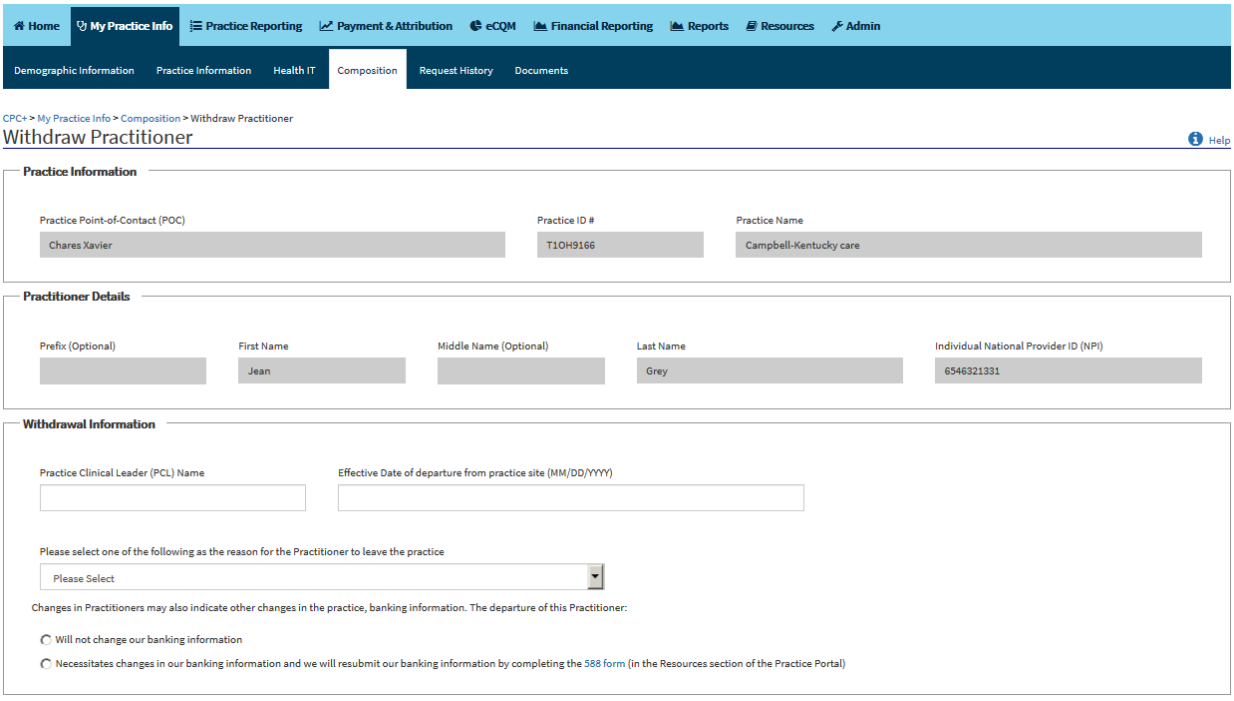


Figure 47: Withdraw Practitioner

Step 5: Updating Staff Roster

The Add New Non-Clinician Staff page displays details necessary for adding a new Non-Practitioner Staff member to your practice (see Figure 48).

If you want to update your Staff Roster:

1. Complete the **Non-Practitioner Staff Details**.
2. Attest the accuracy of the information provided by completing the **Confirmation**.
3. Select **Save**.

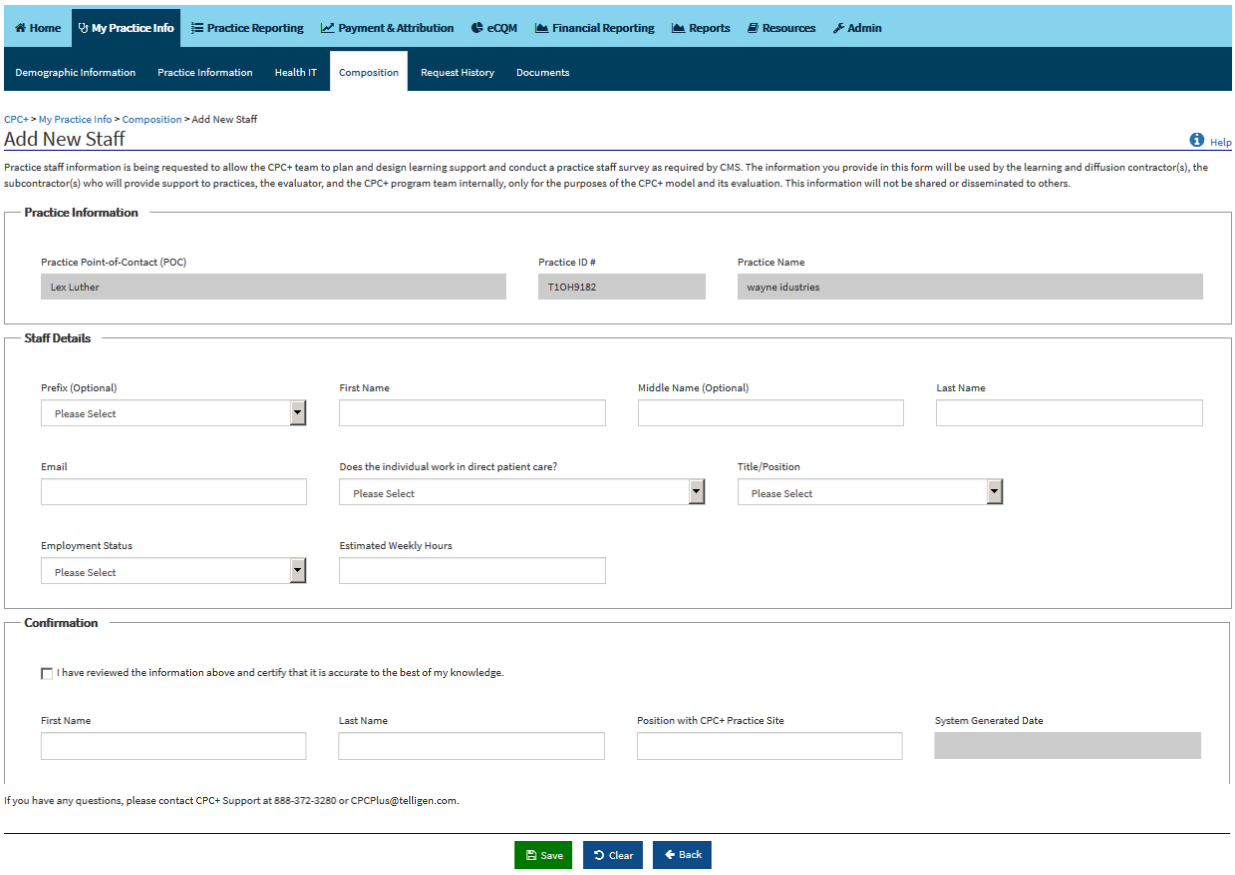


Figure 48: Add New Non-Practitioner Staff

Step 6: Updating Staff Information

The Staff Information page displays the details for non-practitioner staff at your practice (see Figure 49).

If you want to edit Non-Practitioner Staff Information:

1. Select **Update Information**.
2. Make desired changes to Non-Practitioner **Staff Details**.
3. Select **Save**.

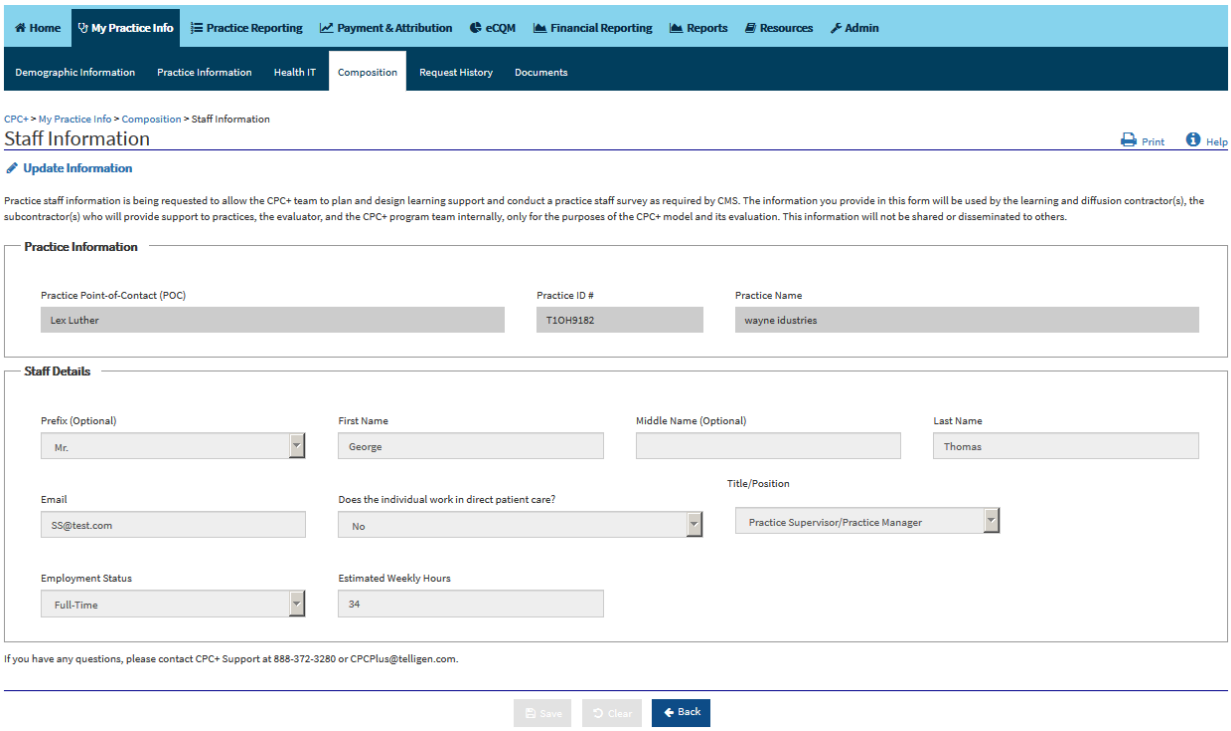


Figure 49: Non-Practitioner Staff Information

Appendix K. Health IT Tab in the CPC+ Practice Portal Information

The **Health IT** tab in the CPC+ Practice Portal will be reopened at the beginning of each CPC+ measurement period and must be filled out each year. It is crucial that your practice's health IT vendor information is current to show CMS the use of health IT vendors to support health IT functions, eCQM submission, and other CPC+ program requirements throughout the five years of CPC+. The Quality and Health IT team will also use the data provided by your practice to track health IT transitions. The information in the **Health IT** tab of the CPC+ Practice Portal should be filled out by a CPC+ Practice Portal authorized user from your practice. The following steps walk you through how to find the **Health IT** tab in the CPC+ Practice Portal and start the process of adding all active health IT vendors used for CPC+. A more detailed user guide of adding a health IT vendor is available on CPC+ Connect for each CPC+ measurement period.

Step 1: Access the Health IT Tab in the CPC+ Practice Portal

1. Go to: https://portal.cms.gov/.
2. Select **Login** to open the CMS Secure Portal.
3. After completing the login process, select **Innovation Center**, then choose **Application Console**, then select **Launch CPC App** to be directed to the CPC+ Practice Portal.
4. Select the **Practice ID** for the practice to which you want to add health IT information (see Figure 50: CPC+ Practice Portal Home Page).

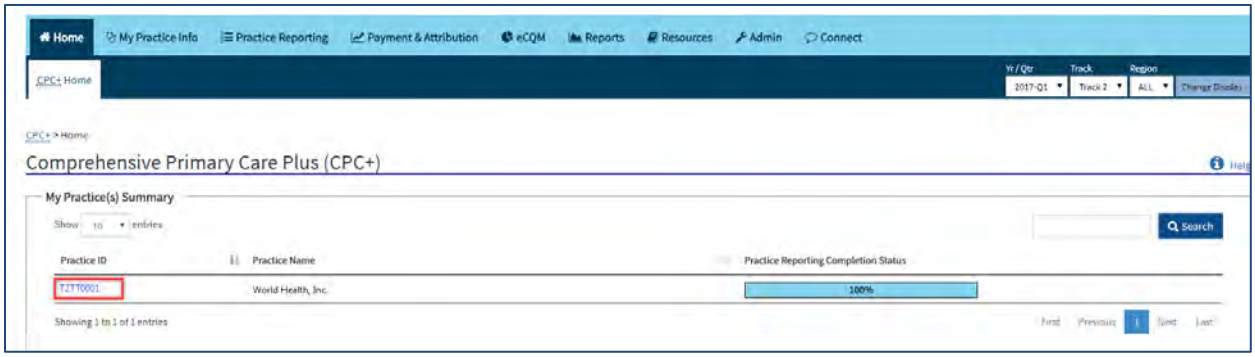


Figure 50: CPC+ Practice Portal Home Page

5. Select **My Practice Info** (see Figure 51: My Practice Info).

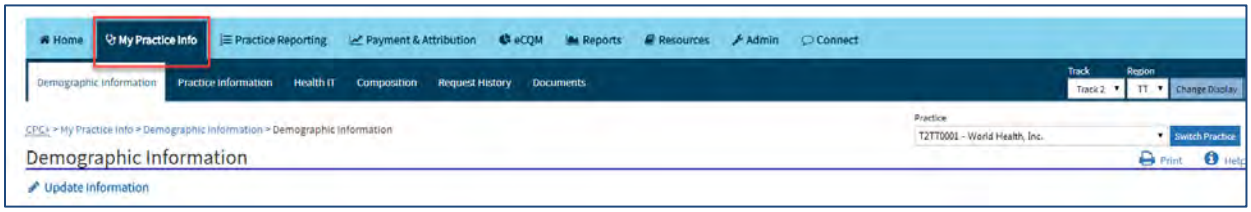


Figure 51: My Practice Info

6. Go to the **Health IT** tab (see Figure 52: My Practice Info – Health IT Tab).

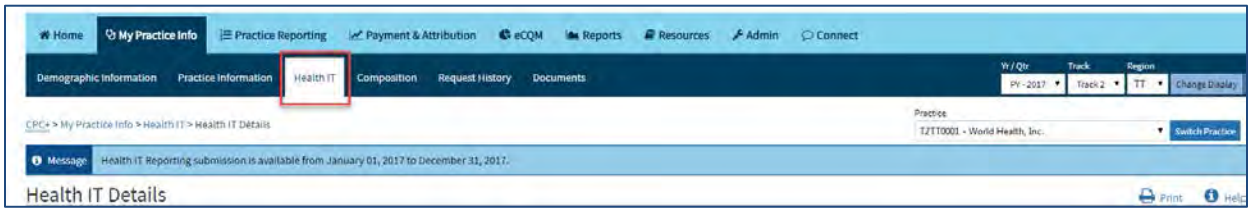


Figure 52: My Practice Info – Health IT Tab

7. Select **Add Vendor** (see Figure 53: Health IT Tab – Add Vendor).

Note: You will have to add one health IT vendor at a time and repeat the same steps for any additional health IT vendors.

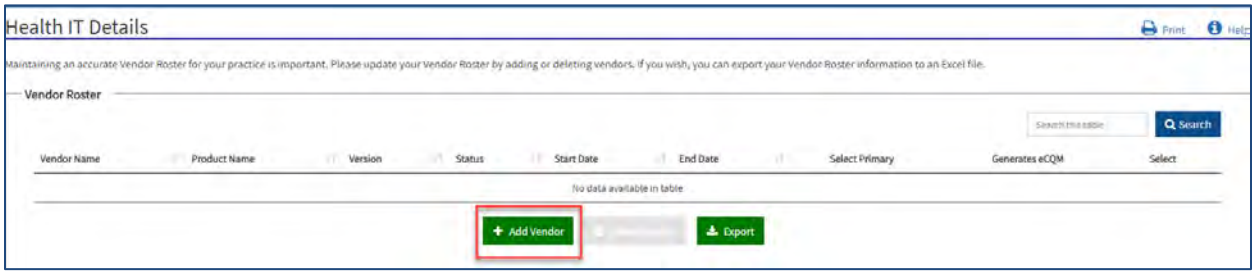


Figure 53: Health IT Tab – Add Vendor

Appendix L. 2018 Quarterly Reporting Frequency Tables

The following tables list the care delivery change concepts you will report on in each quarter. You will complete your reporting in the CPC+ Practice Portal.[77] You can begin your reporting, save it, exit the CPC+ Practice Portal, and return later to continue and finish. The CPC+ Practice Portal will save your answers. Later in the program year, you will be able to look back to previous quarter reports and print them for reference. We encourage you to start your reporting as early in the reporting period as possible.

Table 31 references the reporting items for the Quarter 1.

Table 31: Care Delivery Reporting Period Quarter 1 (3/26/18–4/13/18)

Care Delivery Change Title	
Function 1: Access and Continuity	
(1.1)	Empanelment
1.2	24/7 Access
1.3	Continuity of Care
(1.4)	Enhanced Access and Communication
Function 2: Targeted Care Management	
2.1	Risk Stratification
(2.2)	Identifying Patients for Care Management
2.3	Care Management Staffing
(2.5)	Identifying Hospitals and EDs Your Patients Use
(2.5.1)	Patient Follow-up
Function 3: Comprehensiveness and Coordination	
3.1	Collaborative Care Agreements with Specialists
3.2	Identifying and Communicating with Hospitals and EDs Your Patients Use
3.4	Behavioral Health Integration
3.5	Linkages with Social Services
3.5.1	Coordinating with Social Service Resources
Function 4: Patient and Caregiver Engagement	
(4.1)	Engaging Patients and Caregivers in Your Practice
4.2	Self-Management Support for Selected Conditions
Function 5: Targeted Care Management	
5.1	Team-Based Care
General Information	
(General)	CPC+ Payer Partners
General	CPC+ Program Questions
General	Reporting Point of Contact

When denoted in parentheses (#.#), prior responses for that reporting domain are pre-populated and only require updates.

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

Table 32 references the reporting items for the Quarter 2.

Table 32: Care Delivery Reporting Period Quarter 2 (6/25/18–7/13/18)

Care Delivery Change Title	
Function 1: Access and Continuity	
(1.1)	Empanelment
(1.4)	Enhanced Access and Communication
Function 2: Targeted Care Management	
(2.2)	Identifying Patients for Care Management
2.4	Care Plans
(2.5)	Identifying Hospitals and EDs Your Patients Use
(2.5.1)	Patient Follow-up
Function 3: Comprehensiveness and Coordination	
(3.1)	Collaborative Care Agreements with Specialists
3.3	Comprehensive Medication Management
3.6	Comprehensiveness
Function 4: Patient and Caregiver Engagement	
(4.1)	Engaging Patients and Caregivers in Your Practice
(4.2)	Self-Management Support for Selected Conditions
4.3	Advance Care Planning
Function 5: Targeted Care Management	
5.2	Use of Data to Plan Care
5.3	Continuous Quality Improvement
5.4	Culture of Improvement at Your Practice
General Information	
(General)	CPC+ Payer Partners
General	CPC+ Program Questions
General	Reporting Point of Contact

When denoted in parentheses (#.#), prior responses for that reporting domain are pre-populated and only require updates.

Table 33 references the reporting items for the Quarter 3.

Table 33: Care Delivery Reporting Period Quarter 3 (9/24/18–10/12/18)

Care Delivery Change Title	
Function 1: Access and Continuity	
(1.1)	Empanelment
1.2	24/7 Access
1.3	Continuity of Care
(1.4)	Enhanced Access and Communication
Function 2: Targeted Care Management	
2.1	Risk Stratification
(2.2)	Identifying Patients for Care Management
2.3	Care Management Staffing
(2.5)	Identifying Hospitals and EDs Your Patients Use
(2.5.1)	Patient Follow-up
Function 3: Comprehensiveness and Coordination	
(3.1)	Collaborative Care Agreements with Specialists
3.2	Identifying and Communicating with Hospitals and EDs Your Patients Use
3.4	Behavioral Health Integration
3.5	Linkages with Social Services
3.5.1	Coordinating with Social Service Resources
Function 4: Patient and Caregiver Engagement	
(4.1)	Engaging Patients and Caregivers in Your Practice
(4.2)	Self-Management Support for Selected Conditions
Function 5: Targeted Care Management	
5.1	Team-Based Care
General Information	
(General)	CPC+ Payer Partners
General	CPCP% Selection (Track 2 only)
General	CPC+ Program Questions
General	Reporting Point of Contact

When denoted in parentheses (#.#), prior responses for that reporting domain are pre-populated and only require updates.

Table 34 references the reporting items for the Quarter 4.

Table 34: Care Delivery Reporting Period Quarter 4 (12/31/18–1/25/19)

Care Delivery Change Title	
Function 1: Access and Continuity	
(1.1)	Empanelment
(1.4)	Enhanced Access and Communication
Function 2: Targeted Care Management	
(2.2)	Identifying Patients for Care Management
2.4	Care Plans
(2.5)	Identifying Hospitals and EDs Your Patients Use
(2.5.1)	Patient Follow-up
Function 3: Comprehensiveness and Coordination	
(3.1)	Collaborative Care Agreements with Specialists
3.3	Comprehensive Medication Management
3.6	Comprehensiveness
Function 4: Patient and Caregiver Engagement	
(4.1)	Engaging Patients and Caregivers in Your Practice
(4.2)	Self-Management Support for Selected Conditions
4.3	Advance Care Planning
Function 5: Targeted Care Management	
5.2	Use of Data to Plan Care
5.3	Continuous Quality Improvement
5.4	Culture of Improvement at Your Practice
General Information	
(General)	CPC+ Payer Partners
General	Reporting Point of Conflict
General	CPC+ Program Questions
General	Patient Demographics
Financial Reporting Questions	
Actuals	2018 Revenues
Actuals	2018 Expenditures
Forecast	2019 Revenues
Forecast	2019 Expenditures

When denoted in parentheses (#.#), prior responses for that reporting domain are pre-populated and only require updates.

Appendix M. How to Submit Your CPC+ Financial Reporting

This section of the guide provides you with step-by-step instructions on how to submit your actuals for 2017 and your forecast for 2018 via the CPC+ Practice Portal. We recommend you prepare your reporting before logging into the CPC+ Practice Portal so that you may complete your submission all at once; however, you can save your entries and come back into the system to complete your submission at a later time.

Note: You can work through the financial reporting data entry tabs in any order that works best for you. However, this section guides you in entering all your data relevant to 2017 actuals first (revenues and expenditures) and then entering your 2018 forecast.

Access the CPC+ Practice Portal

You will submit your financial reporting information through the CPC+ Practice Portal (see Figure 54).

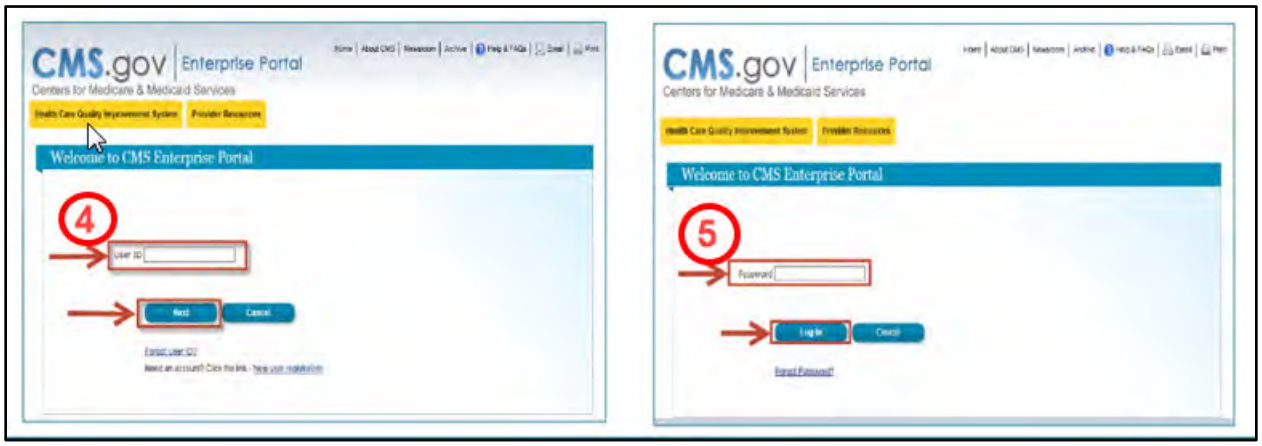


Figure 54: User ID and Password Fields

1. Once you have logged into the CPC+ Practice Portal, click **Financial Reporting** at the top of the page. The **Overview** tab that appears provides you with a quick status of your submission (see Figure 55). As you complete and save your data, the status for each element updates.

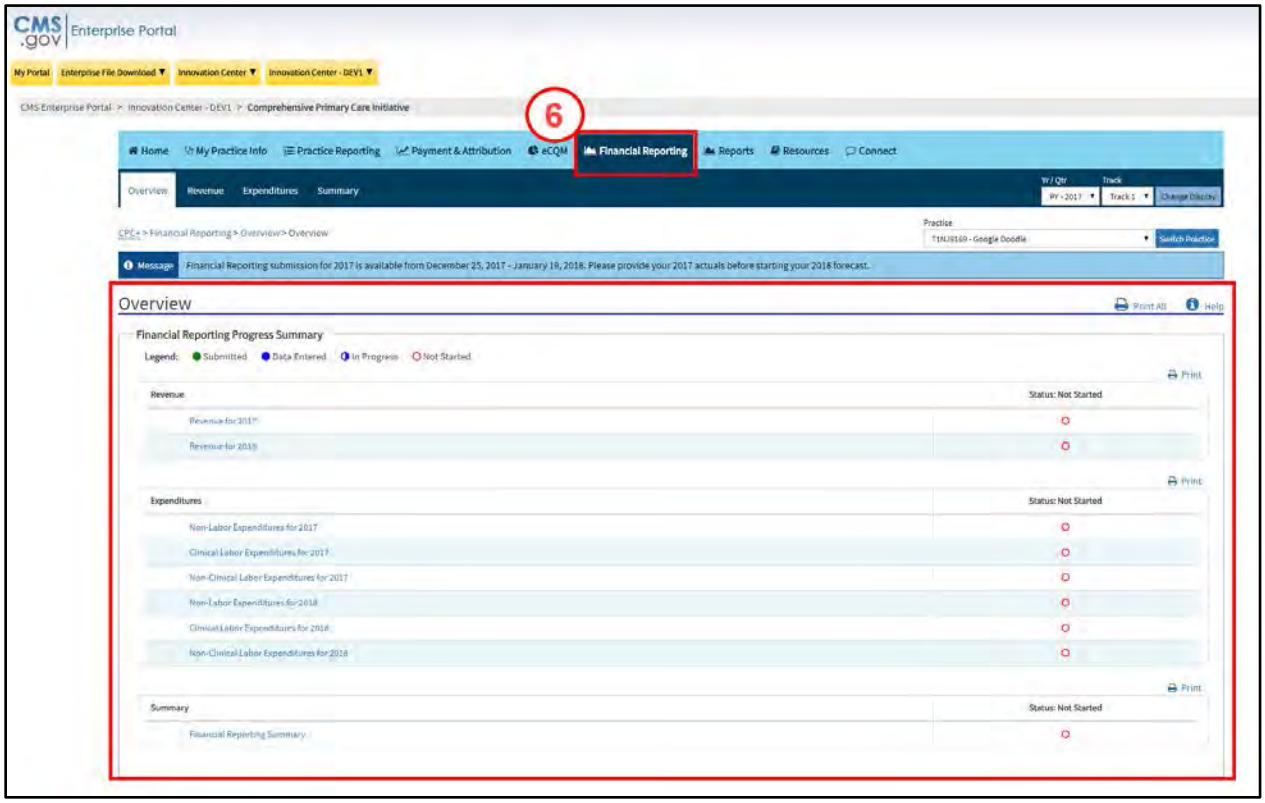


Figure 55: Overview Section

Enter Your Revenue for 2017 (Actuals)

We recommend that you begin by entering your actuals for 2017, starting with revenue. To enter your actual revenues, follow these steps, which are noted in Figure 56:

1. Click **Revenue**.
2. Click **Revenue for 2017**.

   Note: You were not required at the start of Program Year 1 to provide a forecast; therefore, the 2017 forecast fields here appear dark grey and you are not able to enter any information. In subsequent years, the forecast fields on this page will pre-populate based on the forecast information you provide at the start of that year.
3. Select all the CPC+ payer partners that have contracts with your practice (all possible payer partners in your geographic area will display).
4. Click **Add/Remove Payer(s)** and enter the correct revenues from each CPC+ payer partner.
5. Enter your aggregate practice totals for revenue in **Total Practice Revenues** under the Actuals column.

6. Enter the number of active patients in your practice in **Total Active Lives** under the Actuals column.

7. Click **Save**.

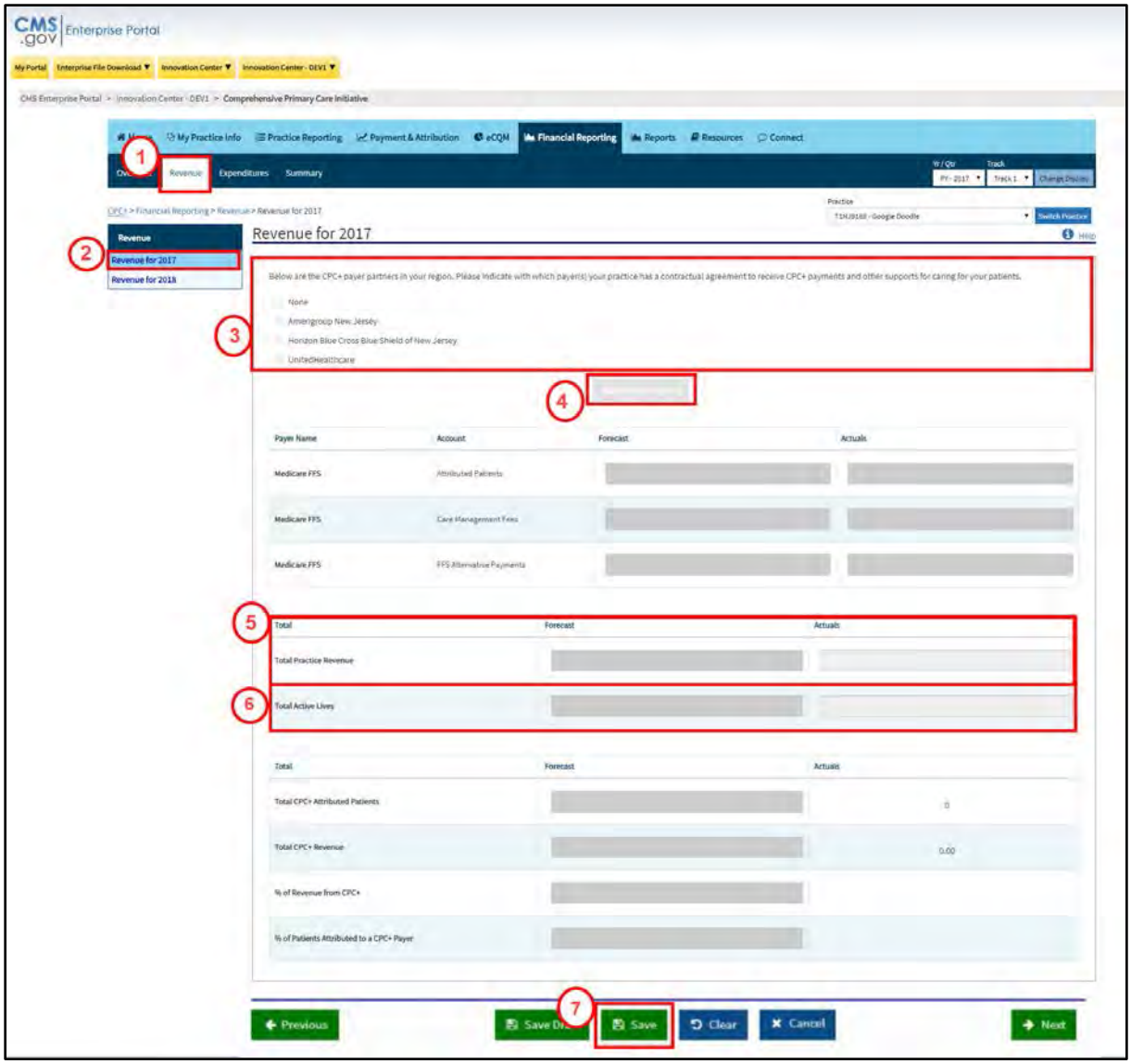


Figure 56: Enter Your Revenue for 2017 (Actuals)

Enter Your Expenditures for 2017 (Actuals)

Under expenditures there are three types of information you need to provide: non-labor, clinical labor, and non-clinical labor. To report your expenditures, follow these steps, which are noted in Figure 57:

1. Click **Expenditures**.
2. Click **Non-Labor 2017**.
3. Under **Non-Labor Expenditures for 2017**, enter your costs in the following fields under the Total Actuals Amount column: **Facilities**; **Supplies**; **Training, Travel, and Conferences**; **Health IT Equipment and Maintenance**; **Non-Health IT Technology**; **Depreciation**; and **Other**.
4. Click **Next**. The Clinical Labor Expenditures for 2017 page appears.

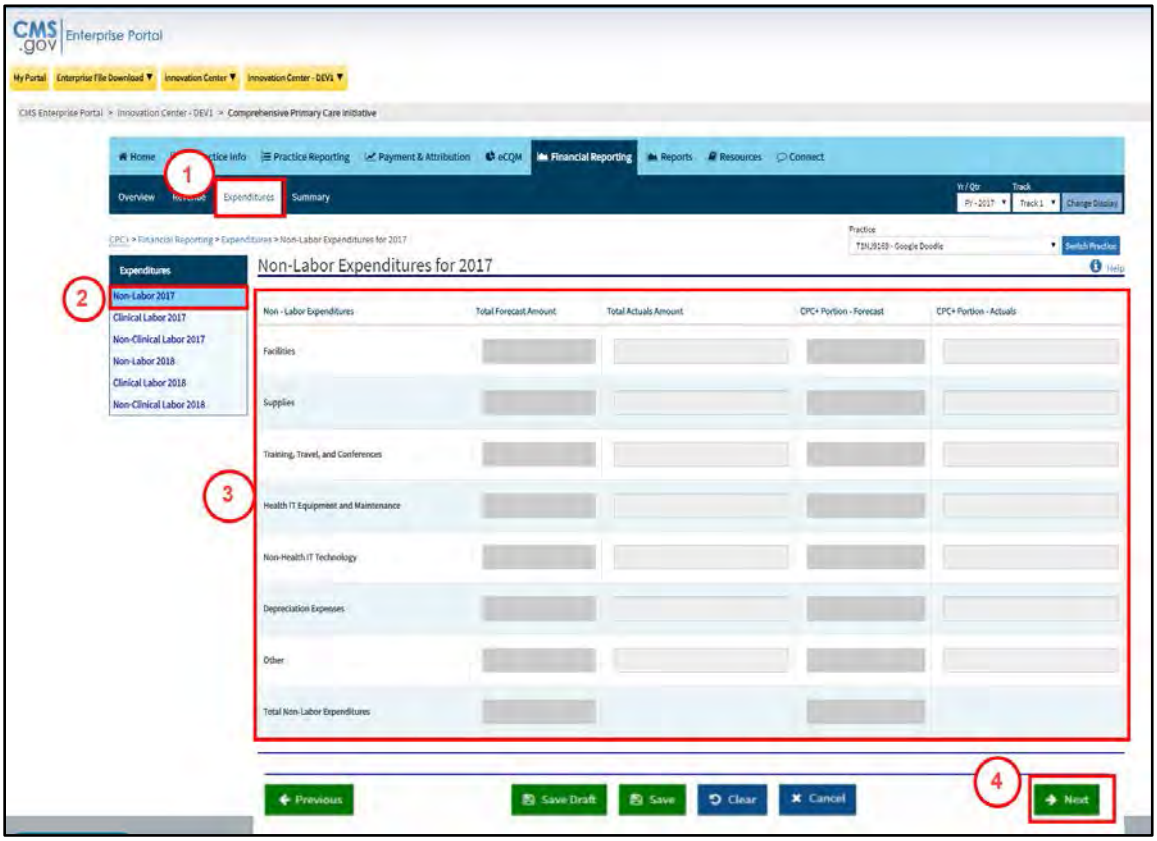


Figure 57: Enter Your Expenditures for 2017 (Actuals)

5. Under **Clinical Labor Expenditures for 2017**, enter your costs in the following fields: **Traditional Visits**, **Alternative Visits**, **Care Management**, **Team Activities & Meetings**, **Care Coordination**, **Quality Improvement & Data Analysis**, **Other CPC+ Activities**, and **Non-CPC+ Activities** (see Figure 58).

6. Click **Next**. The Non-Clinical Labor 2017 page appears**.**

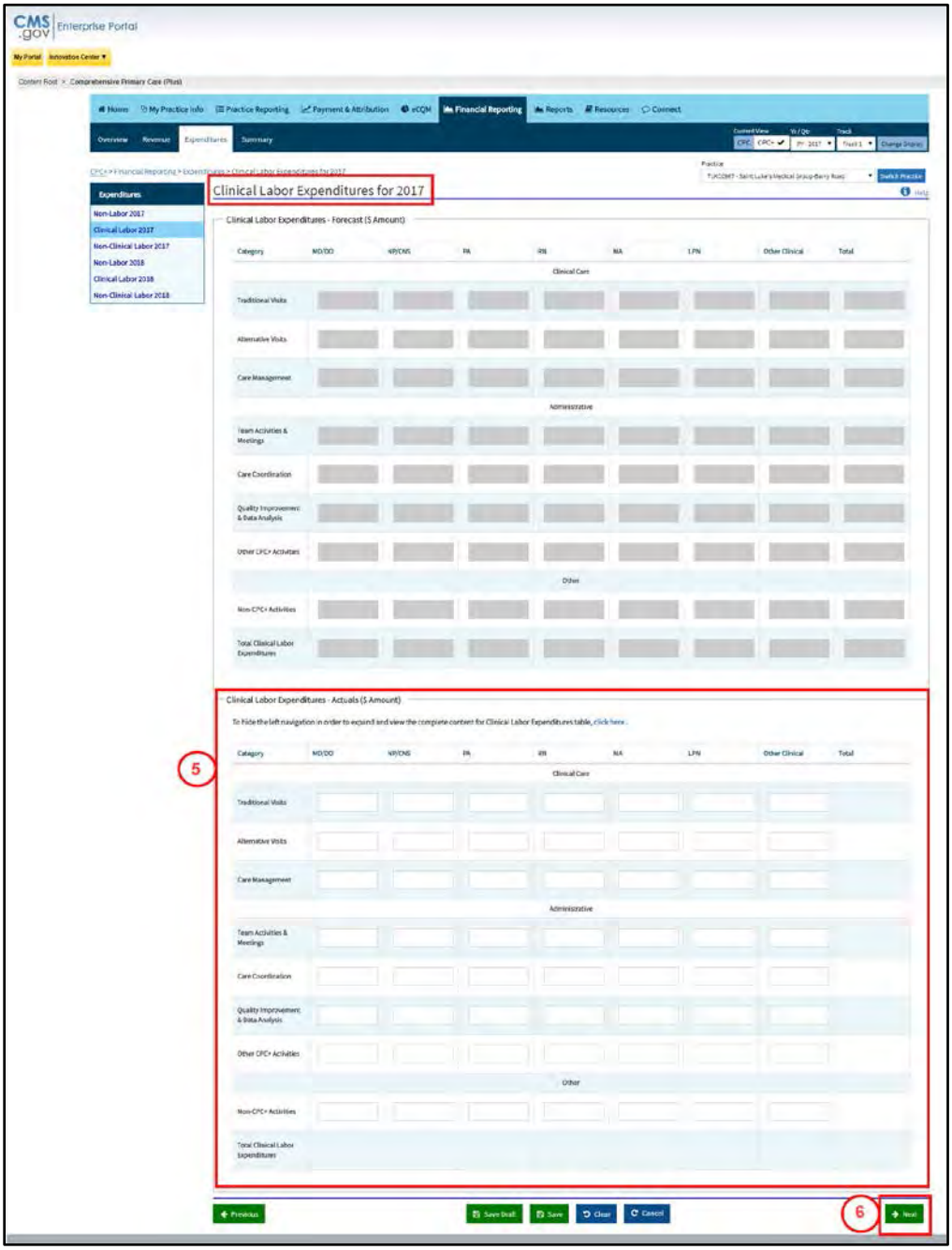


Figure 58: Clinical Labor Expenditures for 2017

7. Under **Non-Clinical Labor Expenditures for 2017**, enter your costs in the following fields: **Traditional Visits, Alternative Visits**, **Care Management**, **Team Activities & Meetings**, **Care Coordination**, **Quality Improvement & Data Analysis**, **Other CPC+ Activities**, and **Non-CPC+ Activities** (see Figure 59).

8. Click **Save**.

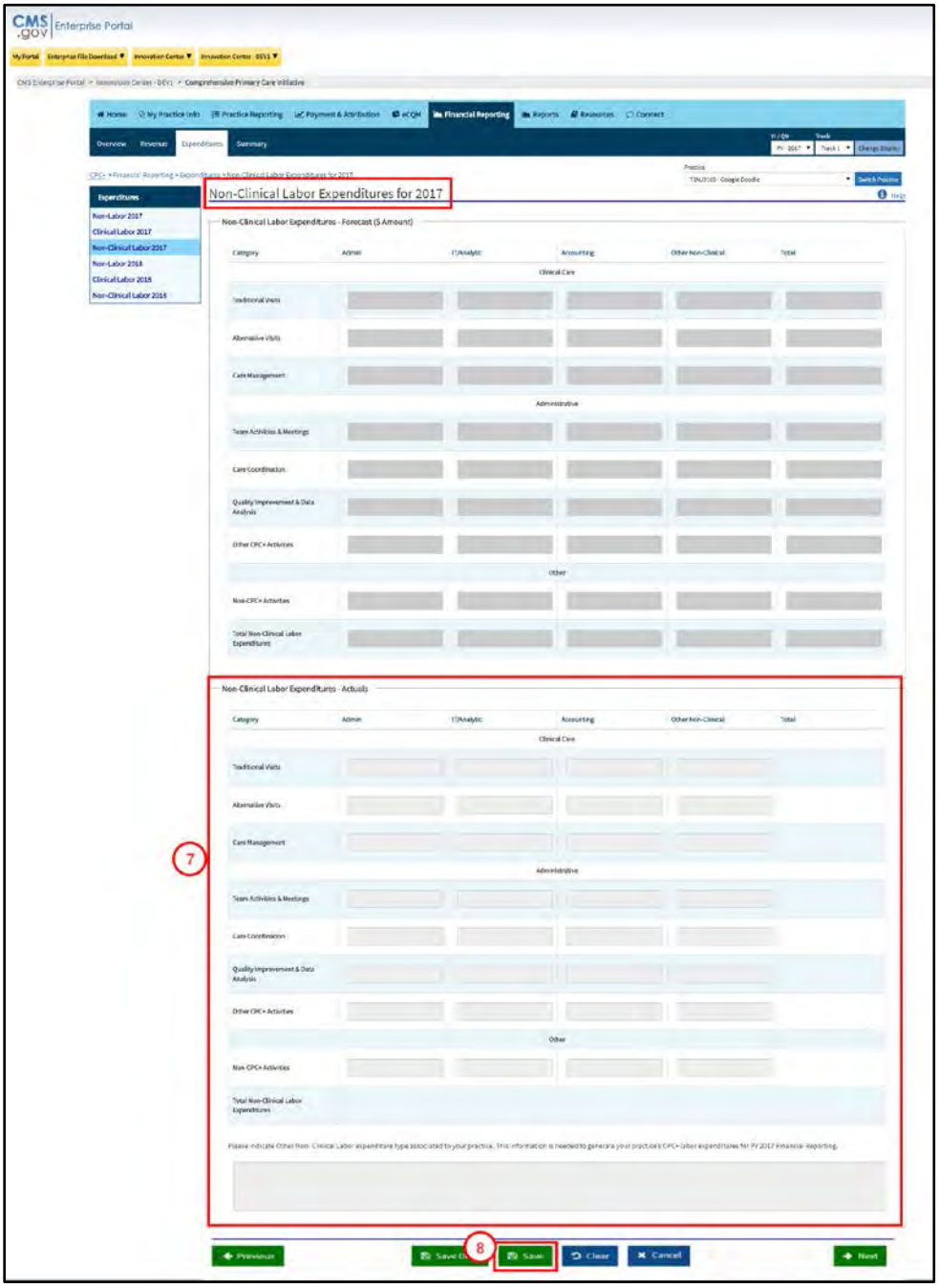


Figure 59: Non-Clinical Labor Expenditures for 2017

Enter Your Revenue for 2018 (Forecast)

To enter your revenue forecast for 2018, follow these steps, which are noted in Figure 60:

1. Click **Revenue**.
2. Click **Revenue for 2018**.

   Note: The 2018 Actuals fields appear dark grey and are not editable. You are not able to enter any information since you are not required to report actuals for 2018 at this time.
3. Select all CPC+ payer partners that have contracts with your practice (all possible payer partners in your geographic area will display).
4. Click **Add/Remove Payer(s)** and enter the correct revenues from each CPC+ payer partner.
5. Enter your aggregate practice totals for revenue in **Total Practice Revenues** under the Forecast column.
6. Enter the number of active patients in your practice in **Total Active Lives** under the Forecast column.
7. Click **Save**.

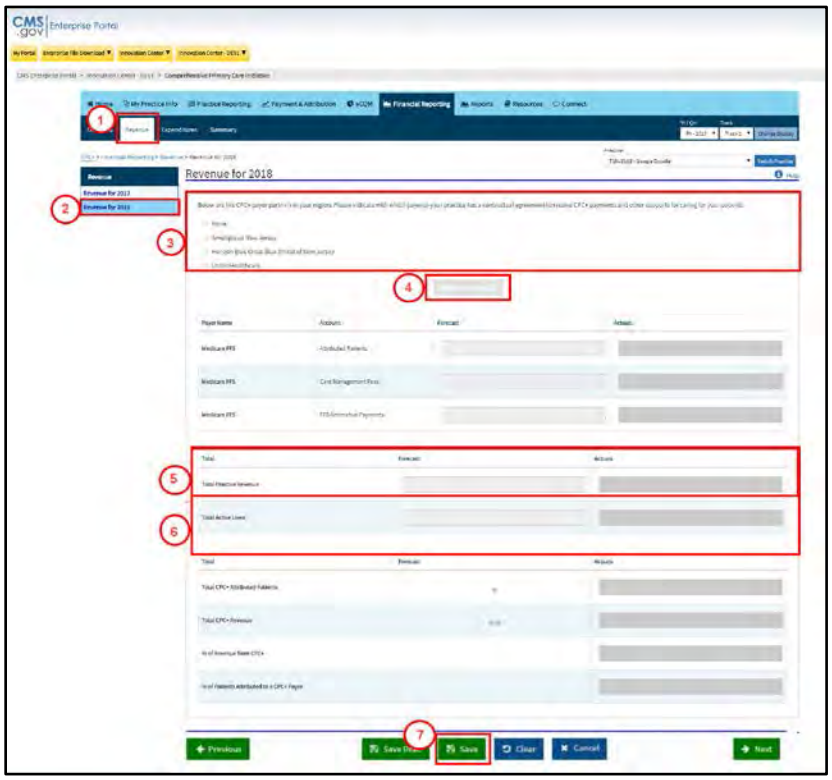


Figure 60: Revenue for 2018

Enter Your Expenditures for 2018 (Forecast)

Just as you did with your actuals, you will provide three types of information—non-labor, clinical labor, and non-clinical labor—when entering your 2018 expenditures forecast. To enter your forecast, follow these steps, which are noted in Figure 61:

1. Click **Expenditures**.
2. Click **Non-Labor 2018**.
3. Under **Non-Labor Expenditures for 2018**, enter your costs in the following fields: **Facilities**; **Supplies**; **Training, Travel, and Conferences**; **Health IT Equipment and Maintenance**; **Non-Health IT Technology**; and **Depreciation and Other**.
4. Click **Next**. The Clinical Labor Expenditures for 2018 page appears.

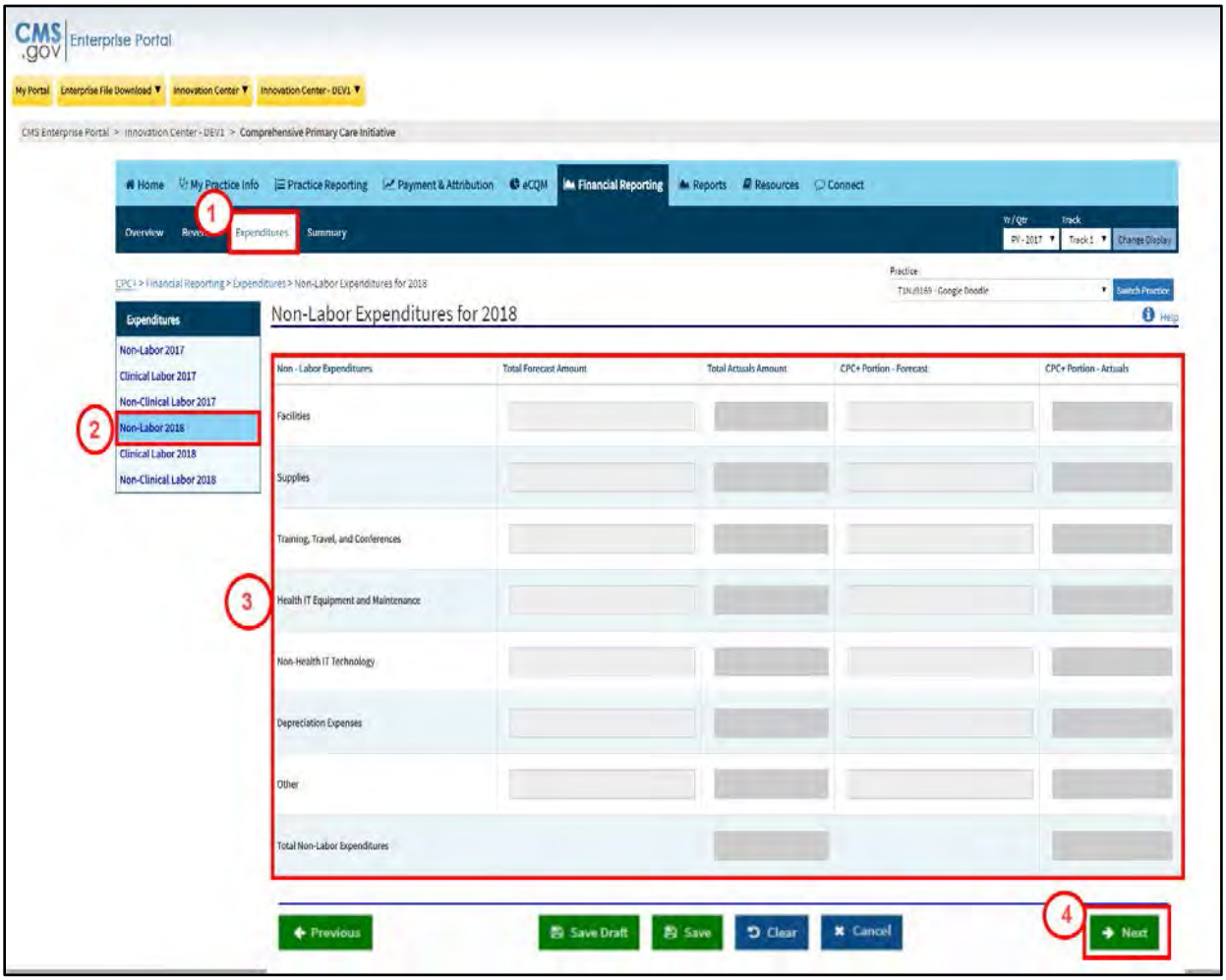


Figure 61:Non-Labor Expenditures for 2018

5. Under **Clinical Labor Expenditures for 2018**, enter your costs in the following fields: **Traditional Visits, Alternative Visits, Care Management, Team Activities & Meetings, Care Coordination, Quality Improvement & Data Analysis, Other CPC+ Activities**, and **Non-CPC+ Activities** (see Figure 62).

6. Click **Next**. The Non-Clinical Labor 2018 page appears**.**

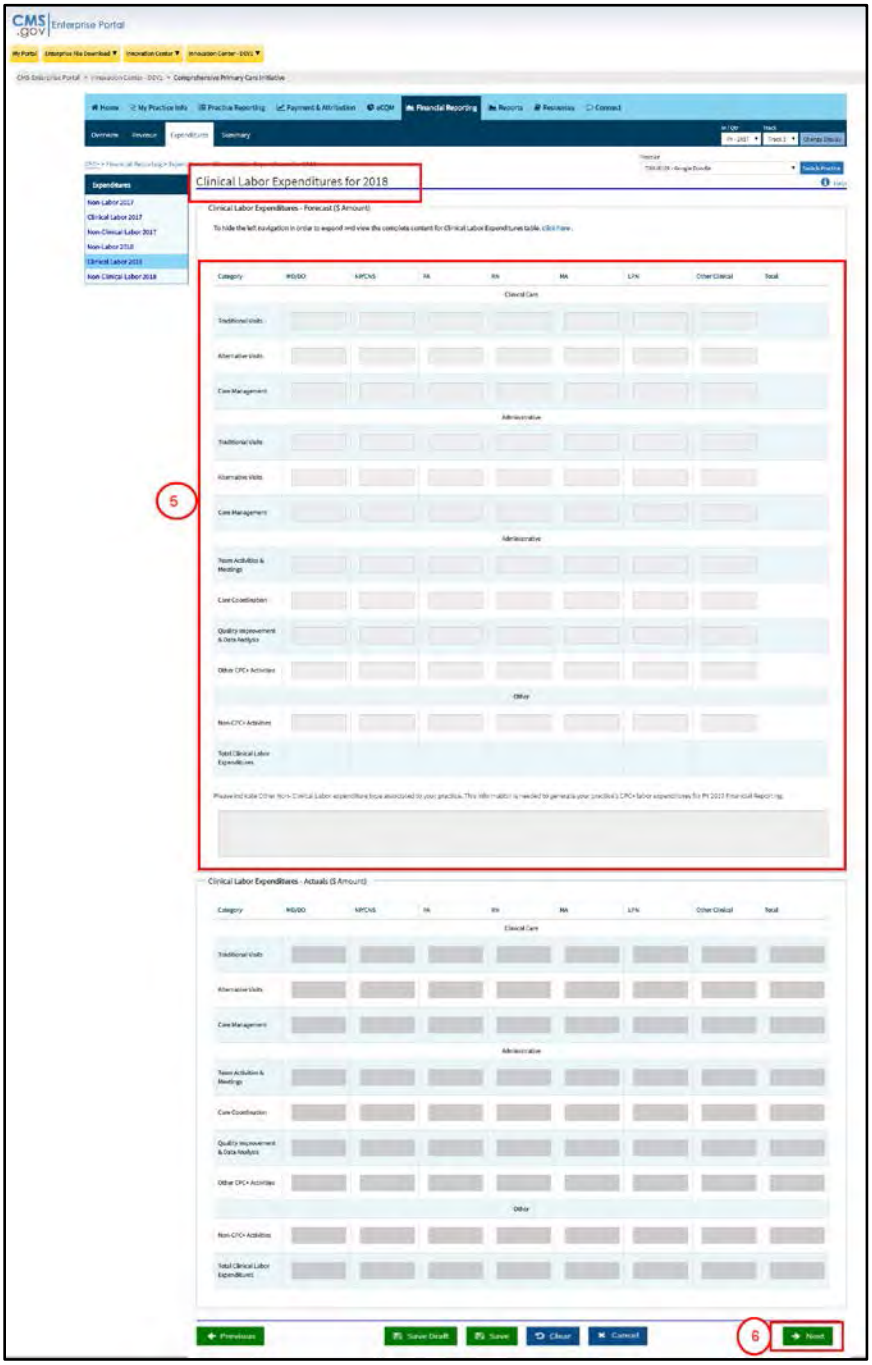


Figure 62: Clinical Labor Expenditures for 2018

7. Under **Non-Clinical Expenditures for 2018**, enter your costs in the following fields: **Team Activities & Meetings**, **Care Coordination**, **Quality Improvement & Data Analysis**, **Other CPC+ Activities**, and **Non-CPC+ Activities** (see Figure 63).

8. Click **Save**.

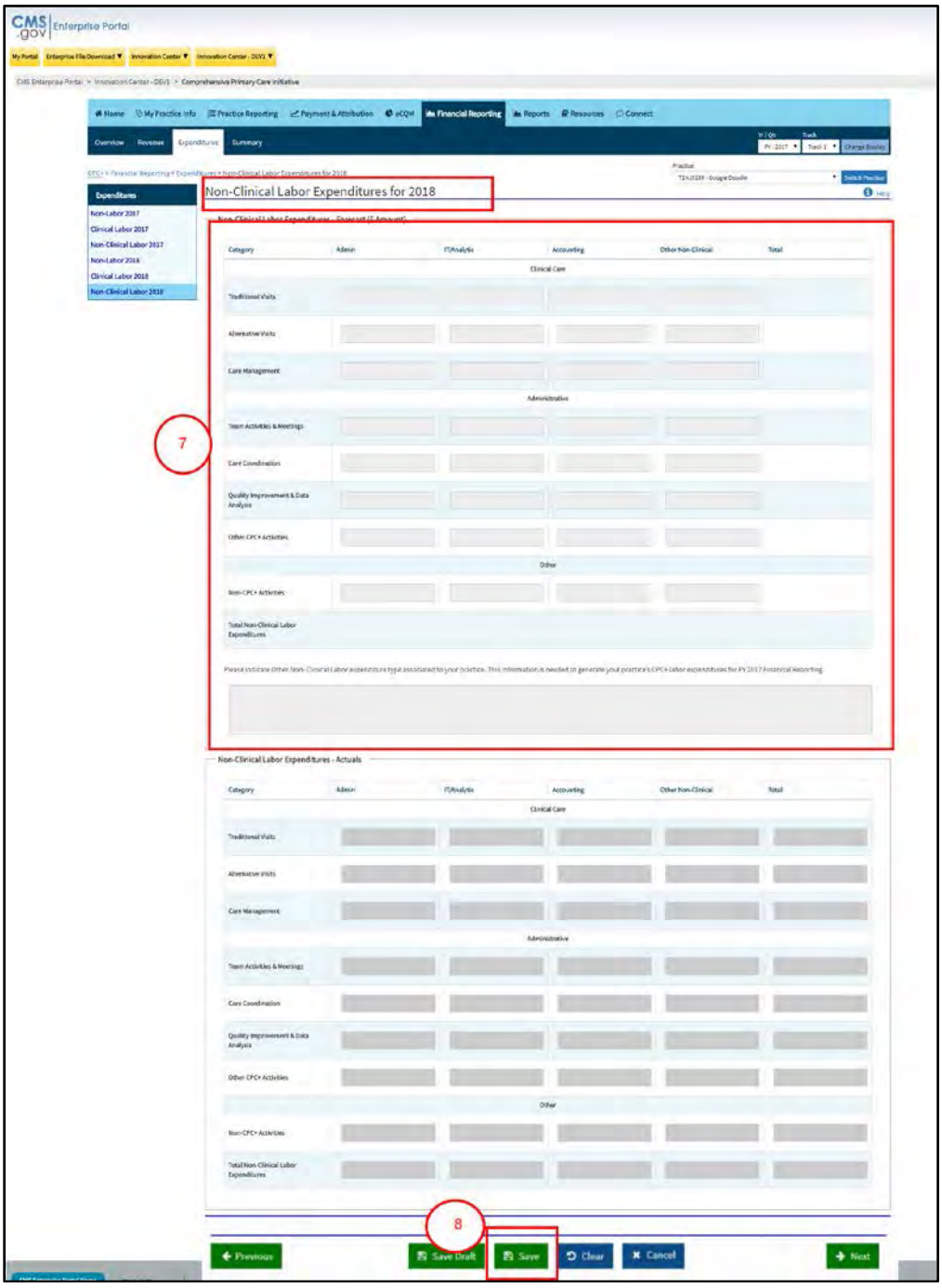


Figure 63: Non-Clinical Labor 2018

Review Your Financial Reporting Summary and Complete the Attestation of Use of Funds

Once you have entered data for both your 2017 Actuals and 2018 Forecast, you will then need to review and attest. To complete this final portion of the process, follow these steps, which are noted in Figure 64:

1. Click **Summary**.
2. Review your financial reporting summary for 2017 and 2018.

   Note: If you need to make updates, use the tabs to navigate to the applicable reporting page to make your updates.
3. Select the attestation checkbox under **Attestation of Use of Funds**.

   Note: The attestation refers solely to use of Medicare Care Management Fees, as described in your CPC+ Participation Agreement. Your financial reporting may include spending in areas that are not permitted uses of the Medicare Care Management Fee. We understand that you may be using other sources of revenue, such as the Medicare CPCP, PBIP, or CPC+ resources from other payer partners, to support that work.
4. Select **Yes** under **Reporting Point of Contact** to attest you are the primary point of contact for financial reporting for your practice.
5. Select the checkbox to acknowledge that you have reviewed the summary information and certify that it is accurate**.**
6. Enter your **First Name**, **Last Name**, and **Position with CPC+ Practice Site**.
7. Click **Submit**.

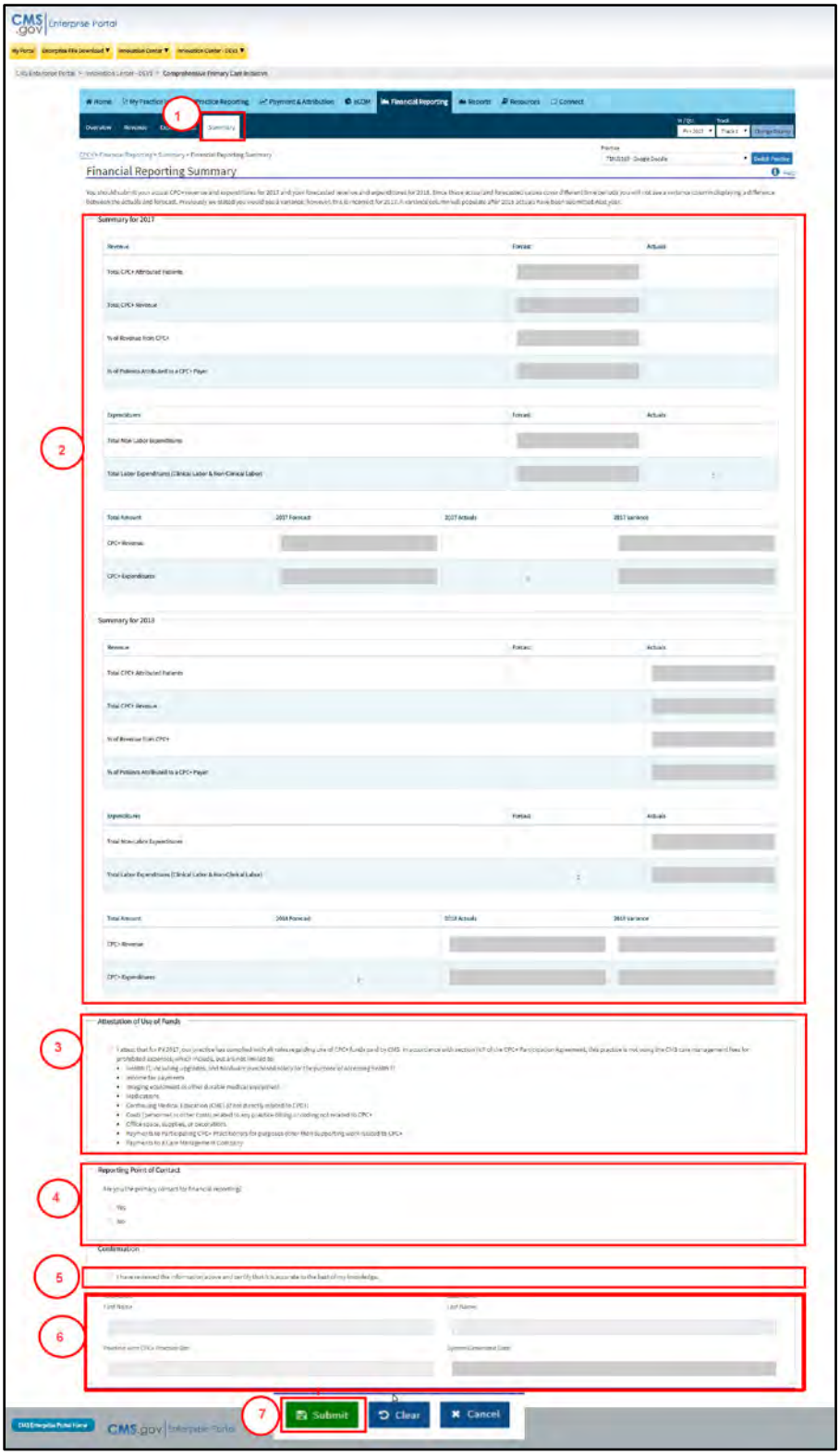


Figure 64: Review Your Financial Reporting Summary and Complete the Attestation of Use of Funds

Appendix N. List of Acronyms

Acronym	Definition
ACCP	American College of Clinical Pharmacy
ACO	accountable care organization
ACP	advance care planning
ACSC	ambulatory care sensitive condition
ADHD	attention-deficit/hyperactivity disorder
ADT	about admission/discharge/transfer
AHC	accountable health communities
APCD	all payer claims databases
APM	alternative payment model
ART	administrative readiness tool
BH	behavioral health
BHI	behavioral health integration
CAD	coronary artery disease
CAHPS	Consumer Assessment of Healthcare Providers & Systems
CBT	Cognitive Behavioral Therapy
CCDS	Common Clinical Data Set
CCM	chronic care management
CCN	CMS Certification Number
CDA	clinical document architecture
CEHRT	certified electronic health record technology
CHAMPS	Community Health Association of Mountain Plain States
CHF	congestive heart failure
CHPL	Certified Health IT Product List
CIHS	Center for Integrated Health Solutions
CKD	chronic kidney disease
CME	Continuing Medical Education
CMF	care management fee
CMM	comprehensive medication management
CMS	Center for Medicare & Medicaid Services
COPD	chronic obstructive pulmonary disease
CPC	comprehensive primary care
CPCP	Comprehensive Primary Care Payment
CPI	Center for Program Integrity
CQM	clinical quality measure
DO	Doctor of Osteopathic Medicine
E&M	evaluation and management

Acronym	Definition
eCQI	electronic clinical quality improvement
eCQM	electronic clinical quality measures
ED	emergency department
EHR	electronic health record
FFS	fee-for-service
HCC	Hierarchical Condition Category
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HISP	Health Information Service Provider
IC	Innovation Center
ICD	International Statistical Classification of Diseases and Related Health Problems
IHI	Institute for Healthcare Improvement
IOM	Institute of Medicine
IVD	ischemic vascular disease
LCSW	Licensed Clinical Social Worker
LOINC	Logical Observation Identifiers Names and Codes
LPN	Licensed Practice Nurse
MA	Medical Assistant
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MATCH	Medications at Transitions and Clinical Handoffs
MD	Doctor of Medicine
MIPS	Merit-Based Incentive Payment System
MLN	Medicare Learning Network
MOU	memorandum of understanding
NP	Nurse Practitioner
NPI	National Provider Identifier
ONC	Office of the National Coordinator for Health Information Technology
PA	Physician Assistant
PAM	patient activation measure
PBIP	Performance-based Incentive Payment
PMPB	per-member per-month
PCMH	patient-centered medical home
PDSA	plan-do-study-act
PFAC	patient and family advisory council
PMPB	per-member per-beneficiary
PMPM	per-member per-month
PRAPARE	patients' assets, risks, and experiences
PROM	Patient-Reported Outcome Measure

Acronym	Definition
PRO-PM	Patient-Reported, Outcome-Based Performance Measure
PST	problem-solving therapy
PY	program year
QI	quality improvement
QP	qualifying APM participant
QPP	Quality Payment Program
QRDA	Quality Reporting Document Architecture
RIDP	remote identity proofing
RN	Registered Nurse
SAMSHA-HRSA	Substance Abuse and Mental Health Services Administration/Health Resources and Services
SBIRT	screening, brief intervention, and referral to treatment
SMS	self-management support
SNF	skilled nursing facility
SNOMED	Systematized Nomenclature of Medicine Clinical Terms
SSN	Social Security number
TIN	Tax Identification Number
VSAC	Value Set Authority Center