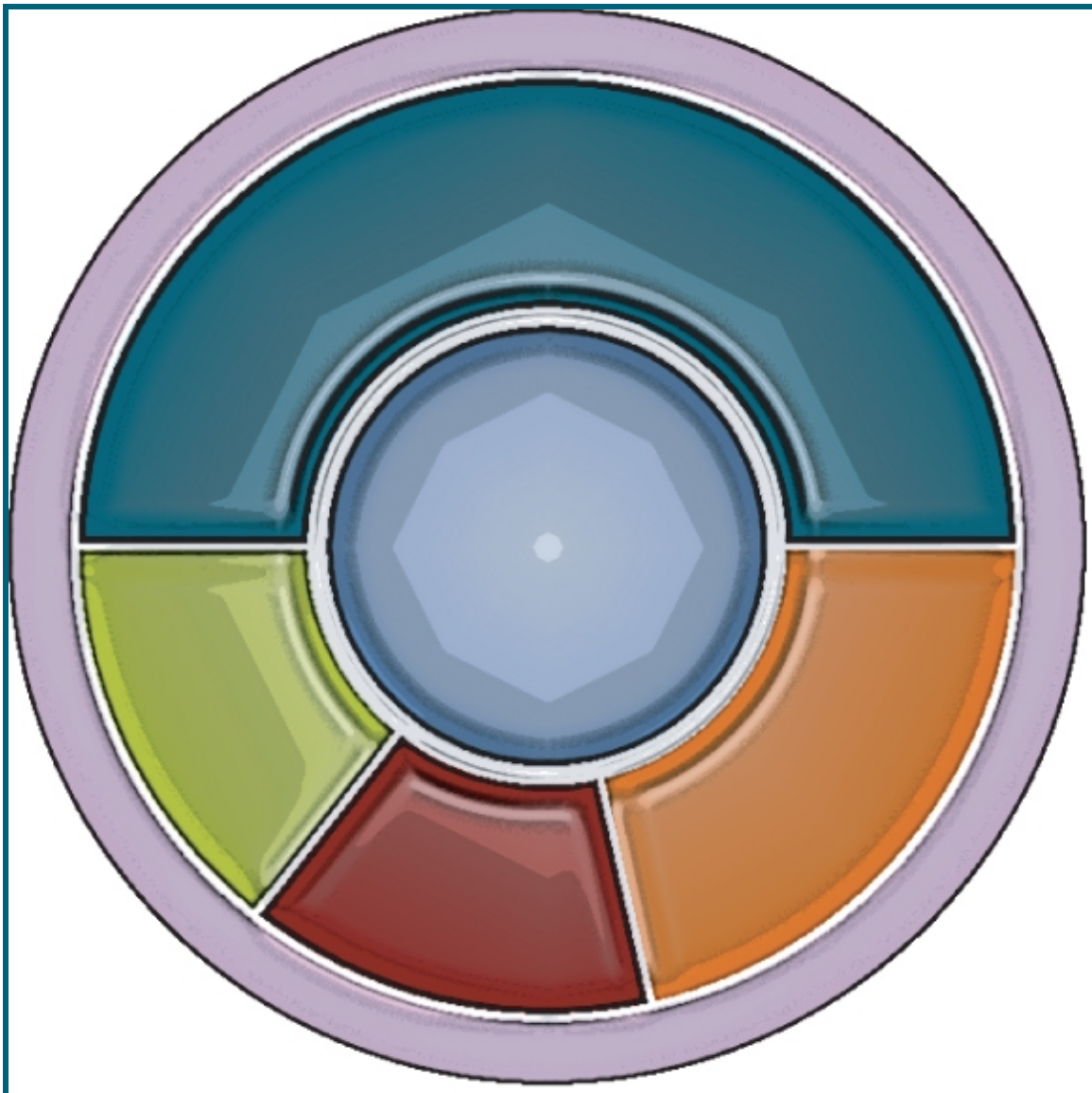


CPC Program Year 2014 Implementation and Milestone Reporting Summary Guide

Updated June 2014

CPC
Comprehensive Primary Care

An Initiative of the Center for Medicare and Medicaid Innovation

What's New in This Update:

This version of the Implementation and Milestone Reporting Summary Guide largely remains the same as the January 2014 version. However content and explanations have been expanded in Milestone 5 (Quality Improvement) and Milestone 7 (Shared Decision Making). The reporting section has been edited to better match the web-based application practices use to document their progress and to expand the list of preference sensitive conditions under Milestone 7.

June 6, 2014

CPC Program Year 2014 Implementation and Milestone Reporting Summary Guide

Introduction

Welcome to the Comprehensive Primary Care (CPC) Program Year 2014! This is your Program Year (PY) 2014 Guide to building capability within your practice to deliver the five CPC primary care functions, with the aim of improving the experience of care and health outcomes, and reducing the overall cost of care for your patients. This Implementation Guide outlines each Milestone by intent, work and reporting requirements. The first part of this Guide covers the Milestone intent and the work you will need to do to achieve the Milestones. We describe what is different from PY 2013 and map out the new capabilities your practice will develop through your work in Milestones 2, 3 and 6. The second part of the Guide walks through the Milestone reporting process, similar to the PY 2013 Milestone Reporting Summary, which many of you told us was very helpful to your practice.

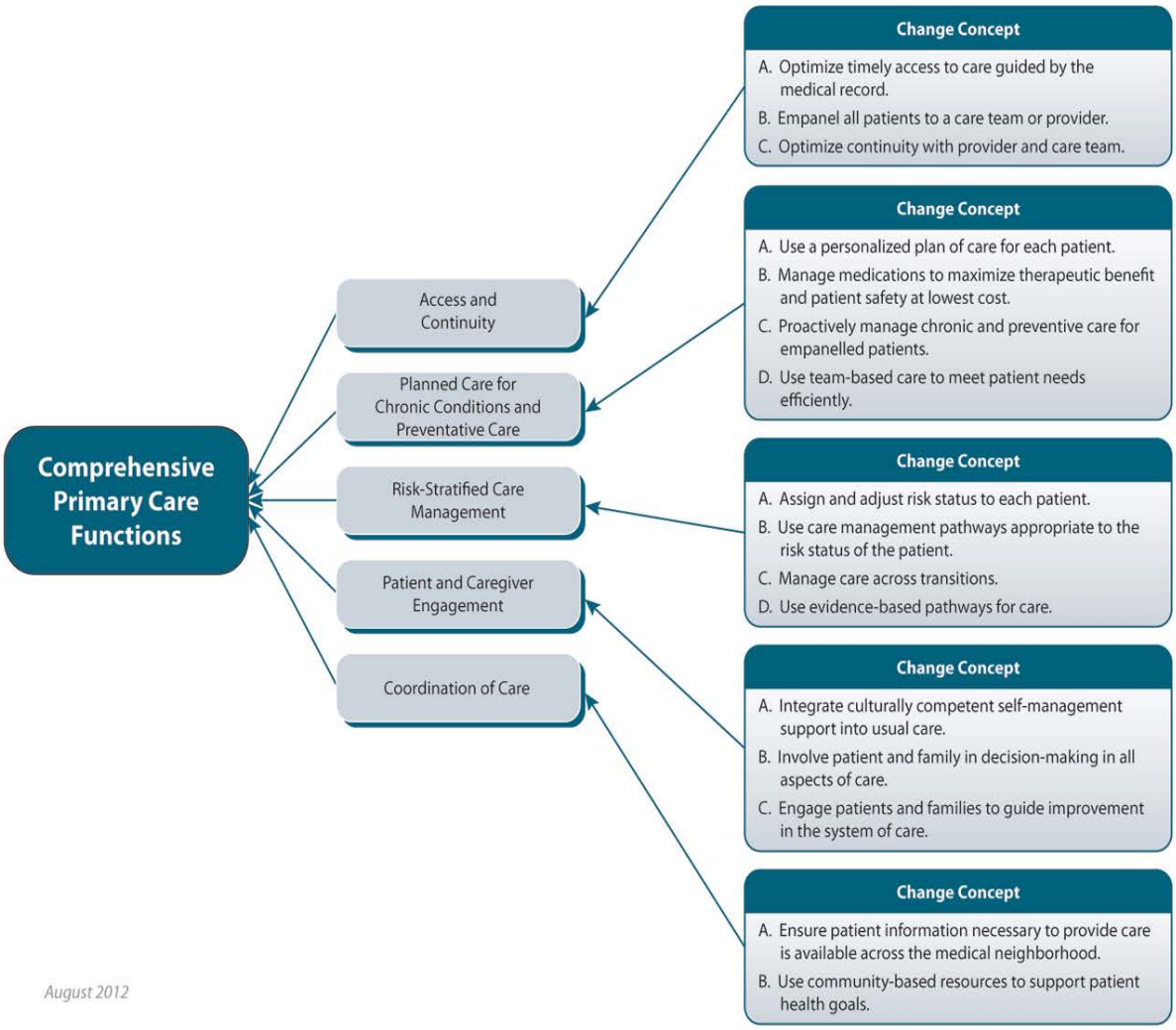
The changes your practice began in PY 2013 through your work in the Milestones will continue and deepen throughout PY 2014 as you consolidate and build on your accomplishments to date. The Milestones are corridors of work that will help you build a practice capable of providing the five primary care functions — Access and Continuity, Planned Care for Chronic Conditions and Preventative Care, Risk-Stratified Care Management, Patient Caregiver Engagement and Coordination of Care (Figure 1). Practices delivering these primary care functions supported by enhanced payment, better data and optimal use of health information technology will improve care, achieve better health outcomes and reduce the total cost of care.

We are excited to hear about your journey and growth in the coming year. We anticipate the first component of the CPC Web Application will be ready for your Milestone 1 (Budget) data in **mid to late February 2014.** Reporting on the remainder of the PY 2014 Milestones will be quarterly rather than one annual report. It is our hope that this quarterly schedule will help your practice team track its work and keep your leadership, CMS, faculty and payer stakeholders aware of your progress and plans. The quarterly reporting will also help faculty gauge your practice's needs for support in the work throughout the year.

Review this Guide **now** and **often**. We hope that it will help you map the work in your practice to successfully achieve the Milestones and integrate the five primary care functions into the care of your patients.

January 28, 2014

Figure 1. Comprehensive Primary Care Functions



The entire CPC Change Package is found [at the end of this document on page 66](#).

Table of Contents

Readers are frequently directed to access resources and materials at the CMS Partner Collaboration website: https://collaboration.cms.gov/. To access hyperlinks to the Collaboration website, you must be a registered user and log in to view those pages.

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Milestone 1: Budget

Intent of Milestone 1

Milestone 1 will help your practice set budget priorities for PY 2014. CPC practices can use budgeting and accounting processes effectively to transform care processes by investing new revenue in priority areas for practice transformation; using accounting, budgeting tools and processes to allocate new revenue; and developing benchmarks and analytic capacity to maximize the likelihood of shared savings. Milestone 1 is an opportunity to create value and support processes of care that align with better health, better care and lower costs through improvement by using productivity measures that include non-visit–related care and incentivizing effective team-based care through non-visit–based payment.

How Milestone 1 addresses the CPC Change Package

Enhanced Accountable Payment

2.1A: Use budgeting and accounting processes effectively to transform care processes.

2.1B: Create value and support processes of care that align with better health, better care and lower costs through improvement.

In PY 2014, Milestone 1 includes reporting the practice site's final funding and costs for 2013 as well as completing a budget projection for 2014. Your practice will be able to enter budget reports on the CPC Web Application by **mid to late February 2014.** The Web Application will close on March 15, 2014, at which time Milestone 1 will be complete.

Milestone 1 Redesigned

CMS redesigned Milestone 1 for PY 2014 after talking with CPC practices of varying sizes, types and regions about their experiences completing the budget for PY 2013. We also reviewed the questions and concerns heard from practices through CPC Support and the Collaboration Site. Based on this feedback, the following changes to the design of Milestone 1 were made:

- Revised some cost categories to address what were sometimes interpreted as overlaps
- Redesigned how to account for EHR and other technology expenditures to improve clarity
- Redesigned how to account for care management and other clinical staffing to improve clarity
- Created a clear way to account for any funding sources outside CPC care management fees that your practice may be leveraging for CPC purposes
- Information regarding final revenues for PY 2014 will only be submitted in early 2015

Please bear in mind that under CPC Terms and Conditions for PY 2014, all information entered into the CPC Web Application may be subject to audit. If audited, we will ask your practice to provide supporting evidence of revenues or expenditures. Please keep all supporting documentation!

The material your practice provides for Milestone 1 is incredibly valuable: it allows CMS to understand your practice's strategies for delivery of high value, comprehensive primary care that can be disseminated to other innovative models and initiatives, as well as allowing your practice and CMS to track progress.

An Approach to Milestone 1

To set the budget for your practice successfully, it is important to consider the resource needs of all PY 2014 Milestones. Using a structured process to plan your budget for PY 2014 is an effective way to determine the financial investments needed to achieve the Milestones. Your practice can approach the work in Milestone 1 in various ways. One approach is to use the 5 Ps framework as described in the book *Value by Design*.[1] This framework is a tested convention that can help you reflect and clarify the investments needed to achieve the CPC aims. The 5 Ps framework supports understanding of the following:

1. needs of the patients served by the practices and the larger system context,
2. ways the professionals in the practice and community interact with one another and
3. ways the professionals interact with the process to produce the critical outcomes.

CPC PY 2014 Terms and Conditions for Milestone 1

a. Record actual CPC expenditures and CPC revenue from Program Year 2013.
b. Complete an annual budget or forecast with projected new CPC Initiative practice revenue flow and plan for anticipated practice expenses associated with practice change in Program Year 2014. This information will be due Quarter 1 of Program Year 2014.

Sample questions using the 5 Ps method to plan a budget:

- *Know your Purpose* – What are our aims or goals for the next 12 months? What do we want to achieve for our patients/practice?
- *Know your Patients* – What can we do address unmet patient needs in the next 12 months? Is there a subpopulation of patients we need to serve differently? What area of care is unsatisfactory to our patients? What do we need to do to engage patients in our practice's changes?
- *Know your Professionals* – What are the skills building and training needs of our staff? What additional type of professional(s) do we need? How are we managing change and supporting staff?
- *Know your Processes* – What technology do we need to support our processes? How do we deliver care and services to meet our patient needs outside of office visits?
- *Know your Patterns* – What are the health outcomes of our patients? What are our reoccurring costs? Are there traditional expectations of staff and patients that we need to strengthen or change to achieve our aims?

The use of the 5 Ps framework is not a CPC program requirement for doing the work necessary to complete Milestone 1. It is provided here to serve as an example of a structured way to gain insights and answer strategic and tactical questions that can lead to a properly resourced plan for PY 2014.

Reporting for Milestone 1

Milestone 1 reporting elements are due in the CPC Web Application by March 15, 2014.

[1]Nelson E, Batalden P, Godfrey M, Lazar J. Value by Design: Developing Clinical Microsystems to Achieve Organizational Excellence. Hanover, NH: The Center for Leadership and Improvement at The Dartmouth Institute for Health Policy and Clinical Practice; 2011.

Milestone 2: Care Management for High-Risk Patients

Intent of Milestone 2

The work in Milestone 2 addresses population health. The priority focus is on those at highest risk for poor outcomes and preventable harm. In PY 2013, your practice began to routinely assess the needs for all of your patients through a risk stratification methodology that applies to every patient in the practice. You built care management capacity into your care team to better address the needs of those patients you identified at highest risk.

In PY 2014, your practice will continue this focus on the patients with the greatest need and potential for preventable harm by matching your risk stratification methodology to your care management resources. This may require refining your methodology or enhancing your care team resources.

New Primary Care Strategies

Three new primary care strategies for PY 2014 offer additional opportunities to enhance your care team to care for those at highest risk and to better support those patients who may be in lower risk strata, but are struggling to achieve their health goals and are at risk for poor health outcomes.

The three primary care strategies — integration of behavioral health (BHI), comprehensive medication management (MM) and routine and effective support for self-management (SMS) of three chronic conditions — add important tools to your practice. Each strategy builds capacity to provide the five CPC primary care functions. Over the course of the CPC initiative, we hope your practice will use all of these strategies as you build capability in your practice to provide comprehensive primary care. For PY 2014 your practice will identify one of these primary care strategies as a starting place. You might choose to start with a strategy that you have already been testing in your practice or you might choose a new strategy to address an unmet need.

How Milestone 2 addresses the CPC Change Package

Access and Continuity:
1.1B: Empanel all patients to a care team or provider.

Planned Care for Chronic Conditions and Preventive Care
1.2A: Use a personalized plan of care for each patient.
1.2B: Manage medications to maximize therapeutic benefit and patient safety at lowest cost.
1.2C: Proactively manage chronic and preventive care for empanelled patients.
1.2D: Use team-based care to meet patient needs effectively.

Risk-Stratified Care Management
1.3A: Assign and adjust risk status to each patient.
1.3B: Use care management pathways appropriate to the risk status of each patient.
1.3C: Manage care across transitions.
1.3D: Use evidence-based pathways for care.

Patient and Caregiver Engagement
1.4A: Integrate culturally competent self-management support into usual care.
1.4B: Involve patient and family in decision making in all aspects of care.

Coordination of Care
1.5B: Use community-based resources to support patient health goals.

Reporting for Milestone 2

Practice-based risk stratification, empanelment and care management remain essential parts of CPC, and your practice will work toward **maintaining at least 95% empanelment to provider(s) or care teams in** PY 2014. Your practice risk stratification process should match available resources. To that extent, we suggest that your practice take another look its risk stratification strategy and, if necessary, refine it using applicable and available data sources and drawing on the experience of your peers in CPC. **The target** is to achieve **risk stratification of at least 75% of empanelled patients** and **provide care management to at least 80% of patients you identified as those at highest risk:** those that are clinically unstable, in transition and/or otherwise need active, ongoing, intensive care management. **Quarterly reporting will include updating information about your practice's risk stratification methodology, empanelment status, risk stratification data and care management staffing and activities.**

CPC PY 2014 Terms and Conditions for Milestone 2

a. Maintain at least 95% empanelment to provider and care teams.
b. Continue to risk stratify all patients, achieving risk stratification of at least 75% of empanelled patients.
c. Provide care management to at least 80% of highest risk patients (those that are clinically unstable, in transition, and/or otherwise need active, ongoing, intensive care management).
d. Implement one or more of the following three specific care management strategies for patients in higher risk cohorts (beginning with those at highest risk):
    1. Integration of behavioral health;
    2. Self-management support for at least three high risk conditions;
    3. Medication management and review

In the **first quarter of PY 2014,** we will ask you to **identify which primary care strategy (BHI, MM or SMS) your practice will pursue** this year. In quarters 2 through 4 your practice will be asked, through a brief series of questions, to **tell us the changes you are making in your practice as you implement this strategy** (while your practice may be pursuing more than one of these three strategies, you will report only on one of them). These questions highlight the requirements for effective implementation of each strategy. The intention of these questions is to help you plan and implement your approach and give us insight into how practices are implementing the strategy. We have not set targets or timelines for this work in PY 2014 but do expect that your practice **address each question every quarter** and **show progress in implementation on a quarterly basis.** It should be the goal of your practice that the answers to the questions indicate that all key aspects of the work have moved out of the planning phase and into active testing and implementation by the end of PY 2014.

The Strategies for Milestone 2

Each of these strategies could be the focus of a major change effort in a practice. In CPC they are integrated into your efforts in Milestone 2 as your practice focuses on meeting the specific needs of your patients in a way that improves the experience of care, improves health outcomes and reduces the total cost of care as a result.

We expect that this work in Milestone 2 will continue to be an active area of practice innovation and learning in CPC and we are eager to learn with you and from you as you implement these strategies into your practice.

For each of the strategies we have identified a CPC Implementation Framework, drawing from the available literature those features that are essential to effective implementation and adapting them to your need to integrate these strategies into Comprehensive Primary Care.

The Implementation Frameworks are intentionally broad, highlighting functions and capabilities rather than tasks because they must apply to the wide variety of practices in CPC. It is best to view them as a way of understanding the critical elements for each of these strategies. The series of questions (Key Questions) that follow the Implementation Framework for each strategy (and are reflective of the questions in the PY 2014 Milestone Reporting Summary) will give your practice insight into the specific steps you can take to build the capability needed for these functions.

A brief guide to resources that can help you get started as you think about how to implement these strategies follows the Implementation Framework and Key Questions. These are not comprehensive and will be supplemented through the CPC national and regional curriculum and sharing from your CPC colleagues on the Collaboration Site as the year progresses.

Integration of Behavioral Health

Behavioral health care is an umbrella term for care that addresses mental health and substance abuse conditions, stress-linked physical symptoms, patient activation and health behaviors. Little of what we do in primary care is unrelated to behavioral health, but most practices have limited resources to support the well-trained clinician in providing this care. While most mental illness and substance abuse presents in primary care, most resources for management of these conditions have been built in silos outside of the primary care practice. The movement toward integration of behavioral health into primary care is, in part, an attempt to bring to the care to the patients where they seek care.

Note:
Behavioral health care: *an umbrella term for care that addresses any behavioral health problems bearing on health, including mental health and substance abuse conditions, stress-linked physical symptoms, patient activation and health behaviors. In CPC, a focus of the integrated behavioral health program can include recognition, diagnosis, assessment, support and treatment of persons with cognitive impairment (including Alzheimer's disease and other dementias).*

CPC Implementation Framework for Behavioral Health Integration

1. The practice is able to identify and meet the behavioral health (BH) care needs of each patient and situation, either directly or through co-management or coordinated referral.
    - The practice has an available range of skills in BH in the practice for primary care management of BH issues.
    - There is a training strategy (formal or on-the-job) to develop capacity for primary care management.
    - The practice has identified and collaborates with appropriate specialty referral resources in the health system (as applicable) and the medical neighborhood.

2. The practice has a systematic clinical approach that:
    - Identifies patients who need or may benefit from BH services
    - Engages patients and families in identifying their need for care and in the decisions about care (shared decision making)
    - Uses standardized instruments and tools to assess patients and measure treatment to target or goal

- Uses evidence-based treatment counseling and treatment
- Addresses the psychological, cultural and social aspects of the patient's health, along with his or her physical health, in the overall plan of care
- Provides systematic assessment, follow up and adjustment of treatment as needed, reflected in the care plan

3. The practice measures the impact of integrated behavioral health services on patients, families and caregivers receiving these services and on target conditions or diseases and adapts and improves these services to improve care outcomes.

Key Questions for Behavioral Health Integration

1. Who provides behavioral health services and what services do they provide? The types of services we are asking about include:
   - Screening/identification
   - Evaluation/diagnosis
   - Evidence-based treatment
   - Referral coordination
   - Tracking and measurement
   - Family and caregiver support
   - Consultation
   - Co-management with primary care

   Where are these behavioral health services? Which ones are part of the practice care team or staff resources your system provides you (for those practices that are part of systems), and which are available through established coordinated relationships in the medical neighborhood?

2. How have you assessed the degree in which your practice has integrated behavioral health into your practice? Tools available to help you assess your practice include:
   - AIMS Center Patient-Centered Integrated Behavioral Health Care Principles and Tasks
   - Integration Academy Self-Assessment Checklist

3. How are you systematically identifying and treating patients in need of integrated behavioral health services? See below for possible strategies:
   - Positive screen on a standardized tool
   - Repeated use of standardized tool to monitor progress and outcomes
   - The presence of specific diagnoses (e.g., depression or anxiety)
   - An inability to reach goals in management of chronic conditions
   - Use of your risk stratification methodology

4. You can incorporate a variety of tools and instruments into your practice to support care. What evidence-based instruments or tools are you using to systematically assess patients and monitor or adjust care? Listed here are examples of tools in current use:
   - Adult ADHD Self-Report Scale (ASRS-v1.1)
   - Audit-C
   - Brief Pain Inventory (BPI)
   - Brief Psychiatric Rating Scale (BPRS)
   - Composite International Diagnostic Interview (CIDI) for depression
   - Drug Abuse Screen Test (DAST)
   - Generalized Anxiety Disorder subscale (GAD-7)

- Global Assessment of Functioning (GAF)
- Mini Mental Status Examination (MMSE)
- Montreal Cognitive Assessment (MoCA)
- Mood Disorder Questionnaire (MDQ)
- Patient Health Questionnaire for Depression PHQ-2 / PHQ-9
- Primary Care PTSD Screener (PC-PTSD)
- PTSD Checklist (PCL-C)
- Yale-Brown Obsessive Compulsive Scale (Y-BOCS)

How do you use the tools above and what team member is responsible? Practices integrating behavioral health use these tools for these functions:

- Identifying the need for care
- Engaging patients in decisions about care
- Planning care
- Monitoring progress and guide treatment to target or goal

5. What evidence-based treatments and counseling does your practice make available to patients in addition to medications when appropriate? Below are examples:
    - Problem Solving Treatment
    - Cognitive Behavioral Therapy
    - Interpersonal Therapy
    - Motivational Interviewing
    - Behavioral Activation

6. Engaging in a systematic case review and consultation for patients in active treatment for behavioral health issues supports treatment to goal or target. How do you identify and follow up with patients who drop out of active treatment? How and when does your practice review patients in active treatment and make specific recommendations for management if the patient is not improving? Who is part of the consultation and review team?

7. How are you building additional capacity for behavioral health in your practice (through training, hiring, contracting, co-management or referral arrangements or other strategies)?

8. How many patients are you currently tracking/managing as receiving behavioral health services? Do you use a stand-alone registry for tracking patients or is this function integrated into your EHR?

9. What measures will you use to assess the integration of behavioral health and the impact of behavioral health services on your patient population? These might be measures of integration such as percentage of patients with a diagnosis of depression who are managed within the practice, key process measures such as percentage of patients with follow up within two weeks of initiating treatment, or measures of effective management, such as percentage of patients with depression who show improvement in scores on PHQ-9 over a period of time. (These are examples only and the identification of useful and effective measures for your practice will be a topic of the learning community.)

Resources for Behavioral Health Integration

The AHRQ Academy for Integrating Behavioral Health and Primary Care

This site provides many resources around integration including the evidence base, the aforementioned lexicon, a quality measures atlas, as well as news worthy items on the topic of integration.

The University of Washington: Department of Psychiatry and Behavioral Health Services—Advancing Integrated Mental Health Solutions

This site provides an overview of mental health integration as well as implementation tools and training materials.

Milbank Memorial Fund: Evolving Models of Behavioral Health Integration by Chris Collins, Denise Levis Hewson, Richard Munger and Torlen Wade May 2010

This site provides eight practice models of behavioral health professional integration.

Patient-Centered Primary Care Collaborative

This site provides successful examples of successfully integrated models from across the country.

The Collaborative Family Healthcare Association

A national organization focused on the integration of behavioral health and primary care.

The University of Colorado Department of Family Medicine YouTube Channel

Several videos on the many aspects of integrated behavioral health and primary care can be found here.

Support of Self-Management

Many patients do not understand what their physicians have told them and do not participate in decisions about their care, which leaves them ill prepared to make daily decisions and take actions that lead to good management. Others are not yet even aware that taking an active role in managing their condition can significantly affect how they feel and what they are able to do. Enabling patients to make good choices and sustain healthy behaviors requires a collaborative relationship: a new health partnership between health care providers and teams, and patients and their families. The partnership should support patients in building the skills and confidence they need to lead active and fulfilling lives.[2]

CPC Implementation Framework for Support of Self-Management

1. The practice team embeds self-management support tactics and tools into care of all patients and has intensive strategies available for patients at increased risk.
    - All members of the care team have basic communication skills to support patient self-management.
    - The practice routinely uses tools and techniques that reinforce patient self-management skills.
    - The practice routinely and systematically assesses the self-management skills and needs for patients with chronic conditions and this information is used to guide support for self-management.
    - The practice has a systematic approach to identifying patients with need for additional support in self-management.

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

- The practice has a training strategy (formal or on-the job) to develop staff/care team capacity to support self-management.

2. The practice uses tactics and tools that support self-management across conditions and supports patient acquisition of specific skills for management of target conditions or diseases.
   - Routine interval follow up with patients about their goals and plans is a critical tactic for supporting patient self-management.

3. The practice is able to measure how self-management support strategies affect target conditions or diseases and adapts and improves these strategies to improve care outcomes.

4. The practice develops and maintains formal and informal linkages to external resources to support self-management.

Key Questions for Support of Self-Management

1. What three high-risk conditions is your practice focusing on for self-management support and what triggers support for self-management? How many of your patients have the condition?

2. How do you help your patients gain the disease or condition-specific skills they need to manage the target disease or condition (beyond education in the context of the E/M [evaluation and management] visit with their physician, nurse-practitioner or PA)? What is the training or credential required to provide this more intensive support (for example, the certification in diabetes education [CDE], or training in asthma self-management)? How many patients received training in managing their disease or condition?

3. What cross-condition strategies does your practice use to support self-management and who on the care team does this? Examples of these strategies include:
   - Between-visit planning and coaching, such as
     - Pre-visit development of a shared visit agenda with the patient
     - Team preparation for the patient (e.g., through huddles or chart reviews)
     - Coaching between visits with follow up of care plan and goals
   - Goal setting and care plan or action plan development
     - Discussion with the patient of his goals and documentation in the EHR
     - Development of a care plan or action plan and documentation in the EHR
   - Peer-led support and counseling
     - Peer-led support for self-management (for example, through chronic disease self-management programs), either in the practice or in the community.
     - Group visits

4. What approach do you use to assist patients in assessing their need for self-management support? Some tools currently in use include:
   - How's My Health
   - Patient Activation Measure (PAM)

5. Some evidence-based counseling approaches can effectively support self-management. Which approaches are you using in your practice and who has training in these approaches? Examples of these approaches include:
   - Motivational Interviewing
   - 5 As
   - Reflective Listening
   - Teach Back

6. Practices can use a variety of tools that practices can use to support self-management. These range from simple worksheets to help patients identify their agenda for a visit to web-based tools like the PeaceHealth Interactive Shared Care Plan. Which tools are you using and who on the care team uses this tool with patients?

7. Your community is likely to have valuable self-management support resources. What community resources do you routinely make available to your patients? How do you make the link, through information only or through formal referral or prescription? Does your relationship with these community resources include feedback on patient participation?

8. How are you building additional capacity for support of self-management in your practice through training, hiring, contracting, referral arrangements or other strategies?

9. What measures are you using to track the impact of support for self-management on care processes, health outcomes or costs for the three specific conditions of focus you have selected? You may already be focusing on these measures in your work in Milestone 5.

Resources for Support of Self-Management

Schaefer J, Miller D, Goldstein M, Simmons L. Partnering in Self-Management Support: A Toolkit for Clinicians. Cambridge, MA: Institute for Healthcare Improvement; 2009. This paper and a variety of tools and resources to support self-management is available at: http://www.ihi.org/knowledge/Pages/Tools/SelfManagementToolkitforClinicians.aspx

Bodenheimer T, Abramowitz S. Helping Patients Health Themselves: How to Implement Self-Management Support. California HealthCare Foundation. December 2010. Available at: http://www.chcf.org/publications/2010/12/helping-patients-help-themselves

The California Healthcare Foundation has also produced videos introducing key concepts in support for self-management. Available at: Techniques for Effective Patient Self-Management and Coaching Patients for Successful Self-Management

The Agency for Healthcare Research and Quality (AHRQ) has a variety of resources for practices that are building capacity in self-management support. Available at: http://www.orau.gov/ahrq/sms_home.html

The Shared Care Plan

The Shared Care Plan Personal Health Record is a web-based tool for patient self-management and communication among care team members. It is a personal health record that lets patients organize and store vital health information and then share it with their family, physicians and others they feel should have access to this information.

Medication Management and Review

Your practice can build a comprehensive system of medication management by integrating pharmacist(s) into the care team. The use of medications for primary and secondary prevention and for treatment of chronic conditions is a mainstay of medical practice. The potential for medication-related harm is increased in the aged individuals with multiple comorbidities and those receiving care from multiple providers and settings. Many medications require scheduled monitoring for safe use. Protocol-guided medication management can improve outcomes in many chronic conditions. Medication reconciliation is a starting point for safer, more effective medication management, but great opportunities exist to more effectively and safely manage medication therapy across transitions of care.

CPC Implementation Framework for Medication Management

1. The practice has integrated a clinical pharmacist or pharmacists as a part of the care team. The integrated pharmacist's roles and responsibilities should include the following:
    - Works onsite
    - Is involved in patient care, either directly or through chart review and recommendations, and documents care in the EHR
    - Participates in the identification of high-risk patients who would benefit from medication management
    - Participates in care team meetings
    - Participates in development of processes to improve medication effectiveness and safety

2. The practice delivers comprehensive medication management services, which includes the following:
    - Medication reconciliation
    - Coordination of medications across transitions of care settings and providers
    - Medication review and assessment aimed at providing the safest and most cost-effective medication regimen possible to meet the patient's health goals
    - Development of a medication action plan or contribution to a global care plan
    - Medication monitoring
    - Support for medication adherence and self-management
    - Collaborative drug therapy management (when within the state's scope of practice)

3. The practice has a systematic approach to the identification of patients to receive medication management services. Criteria could include some or all of the following:
    - Patients in high risk cohorts already defined under Milestone 2
    - Patients who have not achieved a therapeutic goal for a chronic condition
    - Patients with care transitions
    - Patients with multiple ED visits or hospitalizations
    - Patients with high-risk medications or complex medication regimens

4. The practice measures key processes and outcomes to improve medication effectiveness and safety.

Key Questions for Medication Management and Review

1. What comprehensive medication management services does your practice provide beyond routine medication reconciliation? Examples include:
    - Coordination of medications across transitions of care settings and providers
    - Medication review and assessment aimed at providing the safest and most cost-effective medication regimen possible to meet the patient's health goals
    - Development of a medication action plan or contribution to a global care plan
    - Medication monitoring
    - Support for medication adherence and self-management
    - Collaborative drug therapy management

2. How does your practice engage pharmacist(s) as part of the care team? Do you engage pharmacist(s) as employees, through contract, through some other agreement, or are the pharmacist(s) provided to you as a system resource (for those practices in systems)? How much of pharmacists' time do you have per week?

3. How does the pharmacist(s) on your team engage in patient care? Some examples include:
    - Pre-appointment review and planning without patient present
    - Pre-appointment consultation and planning with patient
    - Coincident referral ("warm hand-off") for consultation
    - Follow-up referral or appointment request from the provider
    - Medication review and recommendations in the EHR (asynchronous with visit)
    - Specified medication management appointment or clinic (e.g., warfarin management or lipid management)
    - E-consultations with patients through patient portal or other asynchronous communication
    - Home visit
    - As part of a group visit

4. How are patients selected for medication management services beyond routine medication reconciliation? Some example strategies include:
    - Patients in high risk cohorts (indicate which cohorts)
    - Patients who have not achieved a therapeutic goal for a chronic condition (indicate the eligible conditions)
    - Patients with care transitions (indicate which transitions or any qualifying factors)
    - Patients with multiple ED visits or hospitalizations
    - High-risk medications
    - Complex medication regimens

5. Does your practice provide Collaborative Drug Therapy Management, and if so, for what conditions?

6. Does your practice target care transitions for comprehensive medication management services? If so, what triggers these services? Some examples include:
    - ED visit
    - Hospital admission
    - Hospital discharge
    - NF or SNF admission
    - NF or SNF discharge
    - Referral

    Do you provide this to all patients or those with specific risk factors?

7. What process measures will you use in your practice to improve medication effectiveness and safety?

Resources for Medication Management and Review

Patient-centered Primary Care Collaborative. *Improving Patient Health Through Medication Management.* Available at: http://www.pcpcc.org/guide/patient-health-through-medication-management

Centers for Disease Control and Prevention. *A Program Guide for Public Health: Partnering with Pharmacists in the Prevention and Control of Chronic Diseases.* Atlanta, GA: US Dept. of Health and Human Services; 2012. Available at: www.cdc.gov/dhdsp/programs/nhdsp_program/resources.htm

American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. Available at: http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/2012

Milestone 3: 24/7 Access by Patients and Enhanced Access

Intent of Milestone 3

Milestone 3 work increases access to primary care while supporting the relationships that lead to improved health outcomes. The focus of these changes is on increased access to care outside of the office visit. In PY 2013 your practice built 24/7 access to the electronic health record (EHR) so that, when it matters most, care for your patients can be informed by the data available in the patient's medical record. In PY 2014, your practice will continue to ensure 24/7 EHR access while increasing your patients' access to your care with opportunities for care and consultation outside of office visits.

How Milestone 3 addresses the CPC Change Package

Access and Continuity

1.1A: Optimize timely access to care guided by the medical record.
1.1B: Empanel all patients to a care team or provider.
1.1C: Optimize continuity with provider and care team.

Optimal Use of Health IT

4.1A: Use a certified electronic health record.

Expanding Patient Access

In PY 2014, your practice will also expand patient access to your practice by providing for care and consultation outside of the office visit. This care can be synchronous (happening at the same time, as in telephone visits or instant messaging) or asynchronous (happening at different times, as in email consultation or communication through a patient portal). Obviously, asynchronous communication requires a practice commitment to timely responses, or it simply will not work for patients. This highlights the importance of including all care team members in the discussion around which approaches to care and consultation outside of the office visit are most feasible and achievable in your setting.

Approaching Milestone 3

The planning for this Milestone links to Milestone 1 since this kind of care is not ordinarily compensated. You may want to think about how to make this a care team activity, rather than a provider-centric activity. Planning for this Milestone may also stimulate practice discussion about productivity metrics and internal compensation strategies. Your Patient and Family Advisory Council and CAHPS survey results might also be helpful as your practice considers different options for care and consultation outside of the office visit.

Reporting for Milestone 3

On a quarterly basis, your practice will attest to 24/7 access to the EHR to guide care, and if such access is not currently available you will need to provide a timeframe for implementation. Additionally, there will be quarterly identification of the approach or approaches your practice will take to provide care and consultation outside of the office visit and an estimation of the time your practice staff spends providing that care. This will help us understand the impact of expanding access in this manner. We will also ask you to tell us how you communicate the availability of non-visit care to your patients.

Resources for Non-Visit Access

Viewing Patients as Partners: Patient Portal Implementation and Adoption

This article provides an insight into the experience Patients First (a practice with 21 locations located in east central Missouri) had implementing a patient portal and the benefits their providers and patients received.

E-Visits Versus Office Visits – Researchers Compare Care

This AAFP article by Sheri Porter published on March 13, 2013, describes the benefits and risks related to e-visits vs. office visits for Sinusitis and Urinary Tract Infection. The article encourages providers to explore this option as it relates to patient-centered care and as more and more insurers are getting onboard with payment for this alternative care venue.

Ronald Dixon. Enhancing Primary Care Through Online Communication. *Health Affairs,* 29, no.7 (2010):1364-1369.

This article describes options for online patient communication.

CPC PY 2014 Terms and Conditions for Milestone 3

a. Attest that patients continue to have 24-hour/7-day-a-week access to a care team practitioner who has real-time access to the electronic medical record.
b. Enhance access by implementing at least one type of opportunity for care provided outside of office visits (e.g., through patient portal, email, text messaging, structured phone visit). Communicate a commitment to timely responses to asynchronous forms of communication (portal messages, email, text messages and voice mail).

Milestone 4: Patient Experience

Intent of Milestone 4

The work in Milestone 4 puts the patient and family at the center of care. Your practice will use the Patient and Family Advisory Council (PFAC) and brief, in-office surveys to understand the patient perspective and engage patients and families as partners in improving care.

Practices will continue the PY 2013 work of engaging patients and family as valuable partners, through either office-based surveys or a PFAC. In PY 2014, practices have the additional option of creating a hybrid approach using both office-based surveys and PFAC. The essence of these activities is to use the voice of the patient to guide your efforts to improve care for your patients.

How Milestone 4 addresses the CPC Change Package

Patient and Caregiver Engagement

1.4B: Involve patient and family in decision making in all aspects of care.

1.4C: Engage patients and families to guide improvement in the system of care.

Culture of Improvement

3.2B: Create a culture in which everyone actively participates in improvement activities.

Considerations for Milestone 4 Options

When thinking about which Milestone 4 option best suits your practice setting for engaging patient and families, there are few things to consider:

Option A: Conducting practice-based patient surveys on a monthly basis. Office-based surveys generally use convenience samples and are most valuable when you have multiple data points. The patterns that emerge from the data points will give you a sense of how your practice's changes are affecting your patients' experience of care. Monthly data gives you a much better sense of these patterns and trends. The data will help guide your practice as you test changes on a more rapid cycle.

Option B: Quarterly PFAC meetings. These offer your practice regular and frequent opportunities to collaborate with patients and families for guidance as you test changes in your practice. A highly active PFAC will provide invaluable guidance for your work in all of the CPC functions and Milestones.

Option C: Engaging a PFAC plus conducting office-based surveys. Your practice can gain different kinds of information from each approach and this option allows you to get the best of both.

Communicating Milestone 4 Activities

A new component of the work in this Milestone is to develop material for your patients that will inform them about what you are learning from the surveys and/or Advisory Councils, the changes your practice is making (in services or processes) and the opportunities for them to provide guidance and contribute to future practice improvements. Your patients need to know that your practice is actively working to make care better for them and that you value their engagement with you in this work. The material your practice develops can be in the form of posters, pamphlets, brochures, survey results or other creative communication methods.

Reporting for Milestone 4

Within the reporting application, your practice will make its patient and family engagement selection known in the first quarter.

Option A: Conduct practice-based survey monthly

By selecting Option A, your practice will select at least two CAHPS-PCMH domains for improvement in the first quarter. In subsequent quarters, you will indicate how your practice distributed the survey, the survey results and a brief summary of changes you are testing to address areas for improvement learned from the surveys. Lastly, we will ask you to provide quarterly reports of your practice's approach to communicating survey results, changes in care and patient opportunities for informing change in your practice.

Option B: PFAC that meets quarterly

Reporting on Option B requires quarterly selection of area(s) of focus, indication of the PFAC composition and provision of your practice's PFAC meeting dates. Additionally, your practice will indicate its quarterly approach to communicating the PFAC role and demonstrating its commitment to integrate the patient voice into your practice.

Option C: Office-based surveys administered quarterly and PFAC convened semi-annually

Option C requires your practice to select two CAHPS-PCMH domains in the first quarter and indicate how you distributed the survey, the survey results and a brief summary of changes your practice is testing based on the survey results. Your practice will indicate your PFAC area(s) of focus and composition, and provide the dates for the PFAC meetings. You will also indicate your practice's approach to communicating survey results, PFAC role, changes in care and patient opportunities for informing change in your practice.

CPC PY 2014 Terms and Conditions for Milestone 4

a. Continue year 1 efforts by conducting practice-based surveys and/or meetings with a Patient and Family Advisory Council (PFAC).
   - **Option A:** Conduct practice-based survey monthly.
   - **Option B:** PFAC that meets quarterly.
   - **Option C:** Office-based surveys administered quarterly and PFAC convened semi-annually.

b. Develop communication(s) to patients about the specific changes your practice is implementing (e.g., a pamphlet or posters). The communications should explain the medical care and services at your practice (e.g., new access options, patient portals and access to health information, care management, care coordination, etc.) These are not marketing materials for CPC and should not list the CPC milestones or CPC change package, or contain the CMS logo. The communications should inform patients how to help inform these changes (e.g., through surveys, Patient and Family Advisory Council or other mechanisms).

Milestone 5: Quality Improvement

Intent of Milestone 5

The intention of Milestone 5 is to help your practice take a systematic, EHR-based approach to using data from and about your practice to drive quality improvement. In PY 2013, your practice identified measures for quality and utilization that are important to your practice and patients. Your practice used these measures as guides while you tested changes in your practice. In PY 2014, the work in this Milestone supports your continued work to improve quality of care as measured by the CPC EHR-based Clinical Quality Measures (CQMs).

Starting this year, your practice's ability to report the CPC CQMs will affect your eligibility to share in any savings to Medicare gained by your CPC region. Thus, the work in this Milestone this year is both to report the CQMs at the end of the year and to pay attention to your CQM data as the year progresses. Your practice will need to need to know that at the end of the year you can demonstrate better care and improved health outcomes for your patients as reflected in the CQMs.

How Milestone 5 addresses the CPC Change Package

Allocation of Resources Section

3.1A: Allocate resources to support continuous improvement driven by data.
3.1B: Use available data to guide improvement.

Culture of Improvement

3.2A: Adopt a formal model for quality improvement.
3.2B: Create a culture in which everyone actively participates in improvement activities.

Reporting Your CQM Data

The CQM reporting requirements themselves are covered elsewhere. Please check the Collaboration Site and talk to your Regional Learning Faculty to ensure you understand the requirements. CQM reporting for PY 2014 will occur just once, early in PY 2015.

Reviewing and Learning from Your CQM Data

In addition to the CQM reporting itself, this year's Milestone 5 also asks your care team to make a specific, regular study of your CPC CQM data – and to use what you learn to make practice improvements. Here, we are asking that you get into the regular practice of reviewing CPC CQMs on some regular cycle. This activity is separate from the annual CQM reporting itself. In contrast to the annual CQM reporting, which must take place in a very specific way, the review/learning process around the CQMs could be carried out in a variety of different ways. We ask that you pull CQM data for your whole practice, if possible, as well as at the practitioner or care team level – a useful analysis for quality improvement, even though the CPC CQMs are reported annually only at the practice level. It is up to your practice to design a schedule and process by which you are reviewing the data. Each time you document your improvement work in the CPC Web Application, we ask you which CQMs (picking at least three) you decided to focus on: you may decide to focus on the same CQMs throughout the year, or change your focus over time.

Using this CQM data to guide improvement in care may require new roles or functions within the practice to extract the data from the EHR and present it in an actionable format. This might occur at the system level for practices that are part of a larger system. As your practice attends to this Milestone, you will need to establish

clear data collection and distribution roles among the team, if these are not already in place. Practice providers and teams need to be familiar with reading and interpreting their team and practice level data. Having such a skill will increase the probability that the staff will act on the data to guide improvement.

CPC PY 2014 Terms and Conditions for Milestone 5

a. Report the EHR clinical quality measures required by CPC for your region.
b. Provide panel (provider or care team) reports on at least three measures at least quarterly to support improvement in care.

Note on Milestone 5 terminology: *Milestone 5 asks you to "Provide panel (provider or care team) reports on at least three measures, at least quarterly, to support improvement in care." This use of the word "reports" has been understandably confusing to some practices and EHR vendors. What we mean here is the concept described above of the practice staff regularly pulling, reviewing and learning from at least three CQM data. We do NOT require you to document/report the three CQM data to CMS. Rather, you are required to attest that you are pulling, reviewing and learning from the data. The full CQM reporting for PY 2014 will occur electronically just once, in early PY 2015.*

Milestone 6: Care Coordination Across the Medical Neighborhood

Intent of Milestone 6

The work in Milestone 6 is to develop systematic coordination of care across the medical neighborhood. In PY 2013, practices reached out to willing partners. In PY 2014, your practice will take a more systematic approach when working with hospitals, emergency departments (EDs) and specialists to bridge seams of care for your patients as they transition between settings and providers.

How Milestone 6 addresses the CPC Change Package

Coordination of Care
1.5A: Ensure patient information necessary to provide care is available across the medical neighborhood.
1.5B: Use community-based resources to support patient health goals.

The three care coordination strategies in this Milestone all have the potential to improve care and reduce harm and cost. Due to the uniqueness of your practice some strategies may offer greater opportunities than others.

ED and Hospital Follow Up

Milestone 6 encourages your practice to expand its view of what happens to your patients outside of the primary care office as they receive care from other health care entities in the community. Your practice will need to establish reliable flows of information from EDs and hospitals so you can track your patients receiving care at those settings and follow up with them after the ED visit or hospitalization. This follow-up contact is likely to require new workflow processes in your practice.

Care Compact and Agreements

Another important opportunity for coordinating care lies in creating care compact or agreements that outline respective responsibilities in care and establish reliable exchange of clinical data to guide care with referral specialists. It makes most sense to start with specialists with whom the practice shares a large number of patients.

It is worth noting that the development of medication management strategies and building of care management capacity in Milestone 2 can play an important role in the work of Milestone 6 as your practice make plans to strengthen care coordination with specialists, EDs and/or hospitals.

Reporting for Milestone 6

In the first quarter, your practice will select two out of the three Milestone 6 options to help your patients receive more coordinated care.

Option A: If your practice will **follow up on ED care**, in quarters 1 through 4 you will identify the specific ED(s) of focus and select the method(s) for collecting ED discharge information. In quarters 2 through 4, your practice will provide data on the number of patients discharged from the ED and those that received follow-up contact within one week of discharge.

Option B: If your practice will **follow up on hospitalization,** in quarters 1 through 4 you will identify the specific hospital(s) of focus and indicate the method(s) your practice is using to obtain hospital discharge information. In quarters 2 through 4, your practice will provide data on the number of patients discharged from the hospital(s) and those that received follow-up contact within 72 hours of discharge.

Option C: If your practice will **focus on care compacts or collaborative agreements,** you will identify at least two specialists with whom you have arranged compacts/collaborative agreements in quarters 2 through 4.

CPC PY 2014 Terms and Conditions for Milestone 6

Select two of the three options below, building on your Program Year 2013 activities:

a. Track percent of patients with ED visits who received a follow-up phone call within one week.
b. Contact at least 75% of patients who were hospitalized in target hospital(s), within 72 hours.
c. Enact care compacts/ collaborative agreements with at least two groups of high-volume specialists in different specialties to improve transitions of care.

Resources for Care Coordination

Sample Compact Care Agreements

A range of sample physician-to-specialist agreement forms, including primary care to cardiology, gastroenterology, orthopedics and sub-acute services (for example, a skilled nursing facility).

IHI How-to-Guide: Improving Transitions from Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations

This Guide supports practice-based teams and their community partners in co-designing and reliably implementing improved care processes to ensure that patients who have been discharged from the hospital have an ideal transition back to the care team in the practice.

Care Coordination Agreements: Barriers, Facilitators, and Lessons Learned. Carrier, Emily et al. American Journal of Managed Care. 2012; 18(11):e398-404

Semi-structured interviews with participating providers and national thought leaders in care coordination were reviewed to develop key themes to solutions for effective agreements. Findings include that Care Coordination agreements were most successful in settings where providers had established communications (person-to-person or electronically) as well as existing working relationships.

Chen, AH, Improving the Primary Care-Specialty Care Interface. **Arch Intern Med. 2009;169:1024-1025** Available at: http://archinte.jamanetwork.com/article.aspx?articleid=773522&resultClick=3

Chen, AH, Improving Primary Care – Specialty Care Communication: Lessons From San Francisco's Safety Net: Comment on "Referral and Consultation Communication Between Primary Care and Specialist Physicians" **Arch Intern Med. 2011;171(1):65-67** Available at: http://archinte.jamanetwork.com/article.aspx?articleid=226311&resultClick=3

Forrest, CB, A Typology of Specialists' Clinical Roles. Arch **Intern Med**. **2009**;169:1062. Available at: http://archinte.jamanetwork.com/article.aspx?articleid=415082&resultClick=3

Milestone 7: Shared Decision Making

Intent of Milestone 7

The work in Milestone 7 is to support patients as engaged, informed, and effective partners in their own health care. In PY 2013, your practice tested the use of a decision aid while engaging patients in shared decision making. In PY 2014, *your practice will explore* ***the use of decision aids*** *to support* ***shared decision making*** *between providers and patients* ***in preference-sensitive care****.*

How Milestone 7 addresses the CPC Change Package

Patient and Caregiver Engagement
1.4A: Integrate culturally competent self-management support into usual care.
1.4B: Involve patient and family in decision making in all aspects of care.
1.4C: Engage patients and families to guide improvement in the system of care.

What is Shared Decision Making?

Shared decision making is an approach to care that seeks to fully inform patients about the risks and benefits of available treatments and engage them as participants in decisions about the treatments. (Veroff, Marr and Wennberg at http://content.healthaffairs.org/content/32/2/285.full.html)

What is Preference-Sensitive Care?

Preference-sensitive care comprises treatments for conditions where legitimate treatment options exist — options involving significant tradeoffs among different possible outcomes of each treatment (some people will prefer to accept a small risk of death to improve their function; others won't). Decisions about these interventions — whether to have them or not, and which ones to have — should thus reflect patients' personal values and preferences, and should be made only after patients have enough information to make an informed choice, in partnership with their provider. (The Dartmouth Atlas of Health Care. http://www.dartmouthatlas.org/keyissues/issue.aspx?con=2938)

There is a strong body of evidence that shows significant regional variation in preference-sensitive care and that this variation is not due to patient choice but rather to prevailing practice patterns. There is a growing body of evidence that when patients are engaged in decision-making and provided with the information they need to think through options of care, there is a better match between the care they receive and their health goals and values.

For more information:

- Dartmouth Atlas on Preference-Sensitive Care
- 2014 Cochrane Summary on Decision Aids

It is common practice to offer patients information about tests or treatment options for which there is **clear** evidence for a recommended action (e.g., immunization or USPSTF recommended screening). However, Milestone 7 is focused on engaging patients in making choices when the evidence **does not present a clear best choice** and the "right" treatment or test is the one that best fits their health goals and values. *(See page 62 in the Milestone summary section for a list of some of the most common preference sensitive conditions.)*

What is a Decision Aid?

Decision Aids are interventions designed to support patients' decision making by making explicit the decision, providing information about treatment or screening options and their associated outcomes, compared to usual care and/or alternative interventions. (Cochrane Database of Systematic Review 2014)

CPC PY 2014 Terms and Conditions for Milestone 7

a. Identify and implement shared decision making tools or aids in two health conditions, decisions or tests. Make the decision aid available to appropriate patients and generate a metric for the proportion of patients who received the decision aid.
b. Provide quarterly counts of patients receiving the decision aids and show growth in use of the aids using run charts.

Decision aids provide:

- High-quality, up-to-date information about the condition,including risks and benefits of available options and, if appropriate, a discussion of the limits of scientific knowledge about outcomes.
- Values clarification to help patients sort out their values and preferences.
- Guidance or coaching in deliberation, designed to improve the patient's involvement in the decision process. *(http://www.dartmouthatlas.org/downloads/reports/preference_sensitive.pdf)*

Effective decision aids are not simply informational or instructional. The information in an effective decision aid serves to help patients explore the different options for care and the trade-offs involved and identify their own health goals and values, supporting shared decision making.

So these are the three key components of the work in Milestone 7:

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

The work in this Milestone aligns perfectly with your efforts around support for self-management and patient and family engagement.

Integrating Shared Decision Making into the Workflow

Implementing decision aids should blend into your practice's workflow. To begin, it may be helpful to build a team to help answer the following questions:

- What are some of the more common or important conditions in which you engage your patients in decisions about preference-sensitive care.
- What decision aids will help meet this need?
- What format is mostly likely to appeal to your patients?
- How and who will identify eligible patients for the use of decision aids?
- Where will the decision aids be stored?
- How and when will the patient use decision aids?
- How will your practice know if the process needs to be expanded, changed or refined?

The team can consider including recommendations from PFAC as they determine the best decision aids for your practice and, more specifically, for your patient population. It may be helpful to use the eligibility criteria

provided in each decision aid. In addition to clarifying eligibility criteria for the decision aids, your practice will want to determine who, how and when you will identify the eligible patients for the decision aid. Advanced preparation of the decision aids can streamline the process and allow for better tracking of the distribution.

Tracking Use of Decision Aids

Documenting the use of decision aids will not only facilitate patient follow up, but also enable your practice to track usage of the aids. If your practice mails the decision aids or sends them home for viewing, you will need to have a plan for their return and ensure that the patient has an opportunity to discuss questions and preferences with the provider.

In PY 2014 your practice can choose to track use of the decision aids as a rate (the number of individuals who are given the aid divided by the number who should have been given the aid) or as a simple count of the number of patients provided with the decision aid. This change reflects the difficulty many practices had in reporting on this Milestone in PY 2013.

Reporting for Milestone 7

In the first quarter, your practice will identify at least two health conditions, decisions or tests of focus for SDM and name the source of the selected decision aids. In the subsequent quarters, your practice will report data relative to the eligible patients who received the decision aid. Your practice will have the option to report use of the decision aid as a rate or as a simple count, with an increase in use expected over time.

Resources

For additional information about SDM and Decision Aids for preference sensitive conditions review these resources:

The Informed Medical Decision Foundation website at:
http://www.informedmedicaldecisions.org/imdf_demo_site/massachusetts-general-hospital/

Recent Health Affairs article on SDM and reduced costs of care (NB: subscription required):
http://content.healthaffairs.org/content/32/2/285.long

Preference Sensitive Conditions: http://www.dartmouthatlas.org/downloads/reports/preference_sensitive.pdf

Common list of Preference Sensitive Conditions (page 58): https://collaboration.cms.gov/?q=content/cpc-program-year-2014-implementation-and-reporting-summary-guide

Decision aids to help people who are facing health treatment or screening decisions:
http://summaries.cochrane.org/CD001431/decision-aids-to-help-people-who-are-facing-health-treatment-or-screening-decisions

Milestone 8: Participation in the CPC Learning Collaborative

Intent of Milestone 8

Milestone 8 captures the work involved in participating in both your region's learning collaborative and in the national community of CPC practices. Your practice has a responsibility to actively share in the learning with other practices, regionally and nationally.

How Milestone 8 addresses the CPC Change Package

Culture of Improvement

3.2A: Adopt a formal model for quality improvement.
B: Create a culture in which everyone actively participates in improvement activities.
C: Active participation in transformation collaborative.

Include the Entire Team

Practice transformation is challenging work. The changes required by the PY 2014 Milestones require a committed and coordinated care team with strong and engaged clinical and administrative leadership. Your efforts to change the way your practice works will be more successful if you engage the entire care team in your practice transformation efforts. This requires time to meet as a team and the invitation for all members of the team to contribute ideas and participate in planning for changes in practice workflow and processes.

Who Should Attend Learning Activities

Participation in the regional and national educational offerings supports your practice transformation efforts. A review of the CPC curriculum topics for upcoming events and webinars will help you determine the most appropriate practice representative who should attend the sessions. At least one clinical team member or staff member should participate at each learning session. Ideally, all members of your practice leadership should attend the in-person sessions.

Equally important is the peer-peer learning that takes place when practices share what works and what does not work on national and regional web-based and in-person meetings. This type of collaboration accelerates the pace of learning and innovation that is essential to the success of the CPC initiative.

CPC PY 2014 Terms and Conditions for Milestone 8

a. Participate in all three all-day CPC learning sessions in your region.
b. Participate in one learning webinar per month.
c. Contribute a minimum of one document or experiential story to the CPC Collaboration Website.
d. Fully engage and cooperate with the Regional Learning Faculty, including by providing regular status information as requested, for the purposes of monitoring progress toward Milestones and/or for the purposes of providing support to meet the Milestones. As a contractor for CMS, the faculty is bound by confidentiality agreements.

Reporting for Milestone 8

In the 4th quarter your practice will attest to having participated in three all-day CPC Regional Learning Sessions, participating in at least one learning webinar per month, contributing a minimum of one document of experiential story to the CPC Collaboration Website or the CPC Spotlight and engaging with the Regional Learning Faculty.

Milestone 9: Health Information Technology

Intent of Milestone 9

The work in Milestone 9 uses CPC as a framework for optimal use of your electronic health record in the care of your patients.

Milestone 9 requires that all Eligible Professionals within CPC practices successfully attest to Meaningful Use (MU) and that the practice as a whole adopts EHR technology in line with the most up to date Office of the National Coordinator certification (ONC) standards.

HIT Supports CPC Transformation

Health Information Technology (HIT) offers powerful tools that are essential to providing comprehensive primary care. Practices that invest in the changes in workflow necessary to use the electronic health record effectively can realize the promise of this technology. The registry functions can track patients with increased needs or at increased risk. Automated reminders, alerts and prompts help care teams proactively plan for preventive care and for care of chronic conditions. Templates in the EHR embed decision support into care and help capture key clinical data as structured data.

How Milestone 9 addresses the CPC Change Package

Coordination of Care
1.5A: Ensure patient information necessary to provide care is available across the medical neighborhood.

Allocation of Resources
3.1B: Use available data to guide improvement.

HIT Function
4.1A: Use a certified electronic health record.

Data Exchange
4.2A: Enable the flow of patient information to support care.

Continuous Improvement of HIT
4.3A: Continuously improve function and use of the electronic health record.
4.3B: Hire/train staffs to develop, maintain, and improve EHR function.

Efforts to improve data within the EHR will ensure that clinical quality measurement derived from the EHR truly reflects the quality of care provided in the practice. Regular feedback about important care processes and health outcomes using reports generated from the EHR gives providers and care teams the tools they need to improve care for their patients.

Patient portals offer tools for support of self-management, engagement of patients in shared decision making, and increased access to the provider and care team.

The emergence of health information exchange in CPC regions will improve the quality of the data available in primary care to manage care of the patient and enhance coordination of care in the medical neighborhood.

CPC PY 2014 Terms and Conditions for Milestone 9

a. All eligible professionals in the practice successfully attest to Meaningful Use in accordance with the requirements of the EHR Incentive Program.
b. Adopt and use EHR technology that has been certified in accordance with the Office of the National Coordinator for HIT 2014 Edition EHR Certification Criteria.
c. Identify the care settings/providers for which the practice has the ability to exchange health information electronically.

Reporting for Milestone 9

In the first quarter, your practice will indicate that you are using an ONC-certified EHR. In subsequent quarters, your practice will attest that all Eligible Professionals have successfully attested to MU, and you will identify the settings in which you are able to exchange electronic patient information securely.

Program Year 2014 Milestone Reporting Summary

Please note: *Reporting elements have been tagged with the type of and frequency of information requested to complete the web application. "#" indicates data is required. "X" indicates that a selection is required. "N" indicates a narrative is required.*

Milestone 1: Budget

In Program Year (PY) 2014, your practice will report final funding and costs for 2013 as well as complete a budget projection for 2014. Milestone 1 must be completed in the CPC Web Application by March 15, 2014. Below is a summary of the reporting requirements. The CPC Web Application functionality will be available in ***mid to late February 2014****.*

This Milestone has four sections:

- Program Year 2013 Funding Actual
- Program Year 2013 Costs Actual
- Program Year 2014 Funding Forecast
- Program Year 2014 Costs Forecast

Program Year 2013 Funding Actual

CMS is interested in comparing the CPC care management fee funding your practice site forecasted for 2013 with the actual funding your practice received. If a significant difference appears, we are interested in knowing why you didn't receive what you had anticipated.

For each CPC payer engaged in CPC in your region in 2013, the CPC web application will display the total CPC care management fees you estimated in April 2013. You will then complete the following fields **for each payer**:

1. **Total Care Management Fees *received* for CPC Program Year 2013** (including 2012 Payments)
2. **Reason for Difference Between Forecasted and Actual CPC Funding:**
   Please note: If the difference between Forecasted and Actual CPC Funding was greater than 10%, your practice will be asked to tell us why your forecast differed from the actual care management fees received by checking all that apply:

   - ○ fewer patients **attributed** to our practice than expected
   - ○ more patients **attributed** to our practice than expected
   - ○ **served** fewer patients covered by this payer than expected
   - ○ **served** more patients covered by this payer than expected
   - ○ payments missed by payer(s)
   - ○ timing of payments different than expected
   - ○ delays in contracting with payer
   - ○ contract not established with payer
   - ○ lower per-patient payment amounts than expected
   - ○ higher per-patient payment amounts than expected
   - ○ calculation error in original estimate
   - ○ other (please specify)

3. **Approximate Number of Attributed Lives:**
   Please provide the approximate number of **attributed** lives associated with the payer in CPC Program Year 2013 (the number of lives driving care management fee payments). If you received multiple attribution lists, please calculate or estimate an average attribution number for the year.

4. **Total CPC Payer Penetration in Your Practice Site:**
   Please estimate what percentage of your practice's **total revenue** in Program Year 2013 you received from the CPC payers. **Exclude** CPC care management fees (from all CPC payers) from your calculation of total revenue.

Program Year 2013 Costs Actual

CMS is interested in knowing how your practice site spent the CPC care management funding between program inception and December 31, 2013. Your practice is not required to have spent in accordance with your budget, but we are interested to know the reasons for any differences greater than 10% in each category.

The Program Year 2013 cost categories are the same as those you entered for the PY 2013 budget. You will enter the expenditures at the sub-category level. Where spending differed by 10% or more from forecast in any given category, you will be prompted to give reasons by checking all that apply: practice was able to gain this resource from other funding sources; cost of this resource was **higher** than expected; cost of this resource was **lower** than expected; delay in purchase/hiring; did not need this resource or did not need as much of this resource to meet Milestones; insufficient funding to purchase this resource; needed **more** of this resource to meet Milestones; and other (please specify).

	Original Estimate (*prepopulated*)	**Final Costs**	**Reason(s) for > 10% difference (select all that apply)**	**Notes (*optional*)**
Care Manager(s):				
Salary				
Benefits				
Training				
Interdisciplinary Team Members:				
Custom categories you entered (Pharmacy Consultant, Mental Health, Dietitian, etc.)				
Health Information Technology:				
IT support for implementation and training				
Registry software				
Risk stratification capability				
EHR Quality Metric reporting				
24/7 internet access to EHR				
Patient portal				
Attest to MU 1 – training and IT upgrade				

	Original Estimate (*prepopulated*)	Final Costs	Reason(s) for > 10% difference (select all that apply)	Notes (*optional*)
Risk Stratification Processes and Reporting:				
Practitioner time for development of criteria				
Staff time – training, workflow development				
Proactive Population Management:				
Team meetings				
Protocol development				
Planned visit workflow development				
Non-visit patient interaction				
Shared Decision Making:				
Tool				
Training				
Staff for Expanded Hours:				
Clinic staff				
Nurse call line				
Practitioner-Staff Training & Travel for CPC Learning Activities:				
Leadership training and travel				
Regional Collaborative meetings				
Practice CPC meetings				
CAHPS Survey Administration (Option A):				
Staff Time				
Resources				
Patient and Family Advisory (Option B):				
Staff Time				
Resources				
Other/Miscellaneous:				
Custom categories you entered				

Program Year 2014 Funding Forecast

As in PY 2013, your practice will be asked to forecast your practice site's expected care management fee revenue for each participating CPC payer. The major change for PY 2014 is that you will estimate payments for the **full calendar year.** CMS is interested in expected total revenue, excluding shared savings or other performance-related bonuses. The table below is similar to what you will see in the CPC Web Application.

CPC Payer	**2014 Total Care Management Fee Forecast**	**Approx/Avg Expected Number of Attributed Lives in 2014**
CMS (Fee for Service Medicare)		
Payer 2		
Payer 3		
Payer 4		
SUB-TOTAL		
Do you have any unspent CPC funding from PY 2013 that you will use in PY 2014?		
TOTAL		

Program Year 2014 Costs Forecast

The PY 2014 budget categories are based on the CPC Milestones. Beyond the Milestone-based categories are two categories that cut across and support the Milestones ("EHR" and "overall CPC management"). As in PY 2013, the CPC Web Application will prompt you to enter projected amounts in each of these categories:

- Milestone 2: Risk Stratification/Care Management
- Milestone 2: Self-Management Support
- Milestone 2: Behavioral Health Integration
- Milestone 2: Medication Management and Review
- Milestone 3: 24/7 Access, Non-Visit Based Care
- Milestone 4: Patient Surveys, Patient & Family Advisory Council
- Milestone 5: Quality Improvement & CQMs
- Milestone 6: Care Coordination
- Milestone 7: Shared Decision Making
- Milestone 8: Participation in CPC Learning Activities
- EHR Upgrades/Services for CPC
- Other CPC Program Planning & Operations

For each category above, the Web Application will prompt you to supply the following:

Labor Type	Total number staff	Estimated hours for category per week	Total cost forecast (salary + benefits)
Physician			
PA/APRN			
RN			
MA			
Health Educator			
Behavioral Health Professional			
Pharmacist			
Administrative			
Other, specify			

Non-Labor Type	Total cost forecast	Notes
Travel		
Non-EHR Technology		
Training		
Consulting services		
Vendor-supplied products or services		
Other, specify		

The Web Application will calculate a grand total cost projection and compare it with your total revenue projection from Part III. If your practice's estimated costs are greater or less than projected revenue by 10% or more, you will be prompted to provide a brief explanation.

Milestone 2: Care Management for High Risk Patients

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

Risk Stratification Methodology [Quarterly, X, N]

Identify the data types that your practice uses to risk stratify. The risk stratification methodology your practice develops can use multiple types and sources of data (e.g., clinical, claims, utilization, etc.). The web application will provide a list of possible types and sources for your practice to select, including the option of adding your own data source, if not listed.

Please identify the data types that your practice uses to risk stratify. Select all that apply.

- ○ Claims (payers)
- ○ Clinical (practice, hospital, etc.)
- ○ Utilization
  - o Number of ED visits
  - o Number of office visits
  - o Number of hospitalizations
  - o Level of costs
- ○ Diagnosis
  - o Diabetes
  - o Congestive Heart Failure (CHF)
  - o Asthma
  - o COPD
  - o Depression
  - o Substance abuse
  - o Cancer
  - o Other *(text box will be provided)*
- ○ Level of disease control
- ○ Number of medications
- ○ Score according to algorithm
  - o Publicly available algorithm, please list known criteria
    - HCC risk score (used to assign payment levels from CMS in CPC)
    - AAFP risk score
    - Other *(text box will be provided)*
  - o Proprietary, variables unknown
  - o Other *(text box will be provided)*
- ○ Other psychosocial or behavioral risk factors, please list *(text box will be provided)*
- ○ Clinician judgment of risk

Using the data types above, your practice will **provide a concise narrative describing the approach, methodology or tools used to stratify patients by risk and how this information is recorded in the EHR.**

To show support for the selected approach, your practice may also upload up to three documents such as algorithms or policies and procedures that show your process. If your practice uploads documents, a list or summary of the documents must be added to a provided text box.

Empanelment Status [Quarterly, #]

Provide the status of empanelment at your practice site. In PY 2014, the denominator used to measure empanelment has changed to the **total number of active patients**.

Numerator: Total number of patients empanelled or identified in the EHR as being associated with a primary care practitioner in the practice

Denominator: Total number of active patients

Enter the number of primary care practitioner or team panels at the practice site.

Risk Stratification Statistics [Quarterly, #]

Complete the table (similar to the picture below) to record the total number of patients in the each risk stratum and the number of patients within the stratum that received care managementservices during this quarter. Your practice may enter a **0** if there are no patients in a stratum or if your risk stratification methodology does not have that many strata. Your practice will complete a new table each quarter.

	Total number of patients in stratum:	**Number of patients within stratum that received care management:**
Highest stratum		
Second stratum of risk		
Third stratum of risk		
Fourth stratum of risk		
Low risk/no risk identified		
Not assigned a risk		

Care Management Staff [Quarterly, #]

Describe who on your staff provides care management services. The table below shows the list of providers. All fields in the table are required. A text field will be provided for any additional information that you may want to share with CMS (optional). To save time, the number of practitioners from the previous quarter will be pre-filled in the table. Enter a zero if your practice does not have the specific provider type.

Care management services are provided by:	**Number of practitioners**	**Average patient caseload per practitioner this quarter**
APRN or Nurse Practitioner (NP)		
Medical Assistant (MA)		
Physician (MD/DO)		
Physician Assistant (PA)		
Registered Nurse (RN)		
Health Educator		
Other:		

Care Management Strategy [Quarterly, X, N]

Select the care management activities that your practice uses for its patient population. Select all that apply.

- ○ Patient coaching
- ○ Education
- ○ Care plan development
- ○ Monitoring
- ○ Home visits
- ○ Hospital visits
- ○ Transition management (between both sites of care and providers of care)
- ○ Post-discharge contact
- ○ Other (text box will be provided)

(Optional) You may also provide a description of the care management strategies that your practice is currently using. *Text box will be provided.*

Population-Based Care [Quarter 1, X, N]

Select one or more of the following specific care management strategies for patients at risk. We recommend that these strategies be implemented first with patients who are at the highest risk.

- ○ Integration of behavioral health
- ○ Self-management support for at least 3 high risk conditions
- ○ Integration of pharmacists for medication management and review

Reporting on the Web Application – Behavioral Health Integration [Quarters 2– 4]

1. How have you organized the behavioral health services in your practice? For each of the services, identify who provides the services and how they fit into the system of care.

Services:

- ○ Screening
- ○ Evaluation/diagnosis
- ○ Evidence-Based Treatment
- ○ Referral coordination
- ○ Tracking and measurement
- ○ Family and Caregiver Support
- ○ Peer support
- ○ Other (describe)

After selecting each service, identify who provides for this service. Select all that apply.

- ○ Physician
- ○ PA
- ○ APRN/NP
- ○ RN
- ○ LPN
- ○ MA
- ○ Other Care manager
- ○ Health educator
- ○ Pharmacist
- ○ Behavioral Health Specialist (specify what discipline)
- ○ Other

For each provider selected, you will select a description of where they are in the system of care:

- ○ Practice care team
- ○ Available outside of the practice through contract or as a system resource (for practices that are within systems)
- ○ Available through coordinated referral in the medical neighborhood

2. Which assessment of behavioral health integration have you used to assess your practice?
   - ○ AIMS Center Patient-Centered Integrated Behavioral Health Care Principles and Tasks
   - ○ Integration Academy Self-Assessment Checklist
   - ○ Other (specify)
   - ○ In planning

3. How are you identifying patients in need of integrated behavioral health services? Select all that apply.
   - ○ Use of your risk stratification methodology
   - ○ Positive screen (indicate screening tool used from the pick list in question 4 below)
   - ○ The presence of a specific diagnosis (indicate diagnoses)
   - ○ Inability to reach goals in management of chronic conditions (indicated target chronic conditions)
   - ○ Other (specify)
   - ○ In planning

4. Provide a concise narrative identifying how many patients are currently receiving integrated behavioral health services and being tracked in your EHR or standalone registry. *Text box will be provided*.

5. What evidence-based instruments or tools are you using to systematically assess patients and monitor or adjust care? Select all that apply.

Broad measure:	○ Brief Psychiatric Rating Scale (BPRS)
Depression/ mood disorders:	○ Patient Health Questionnaire for Depression PHQ 2 PHQ-9 ○ Mood Disorder Questionnaire (MDQ) ○ Composite International Diagnostic Interview (CIDI) for depression
Anxiety:	○ Generalized Anxiety Disorder subscale (GAD-7)
ADHD:	○ Adult ADHD Self-Report Scale (ASRS-v1.1)
Pain:	○ Brief Pain Inventory (BPI)
OCD:	○ Yale-Brown Obsessive Compulsive Scale (Y-BOCS)
PTSD:	○ PTSD Checklist (PCL-C) ○ Primary Care PTSD Screener (PC-PTSD)
Alcohol use disorder:	○ The Alcohol Use Disorders Identification Test (AUDIT-C) ○ Drug Abuse Screen Test (DAST)
Cognitive function:	○ Montreal Cognitive Assessment (MoCA) ○ Mini Mental Status Examination (MMSE) ○ Mini-COG
Other (specify):	

For each tool or instrument selected, identify when/how it is applied or used:

- ○ Identifying need for care
- ○ Engage patients in decisions about care
- ○ Plan care
- ○ Follow up and monitoring
- ○ Other (describe)

After selecting each tool or instrument, identify the team members responsible for applying or using that tool. Select all that apply.

- ○ Physician
- ○ PA
- ○ APRN/NP
- ○ RN
- ○ LPN
- ○ MA
- ○ Other Care manager
- ○ Health educator
- ○ Pharmacist
- ○ Behavioral Health Specialist (specify what discipline)
- ○ Other

6. What evidence-based treatments does your practice make available to patients in addition to medications when appropriate? Select all that apply.
   - ○ Problem Solving Treatment
   - ○ Cognitive Behavioral Therapy
   - ○ Interpersonal Therapy
   - ○ Motivational Interviewing
   - ○ Behavioral Activation
   - ○ Other (specify)
   - ○ In planning

7. How and when does the practice do systematic case review and consultation (review of patients in active treatment with specific recommendations for management of patients is not improving) and outreach to patients who have dropped out of treatment?

Systemic Case Review and Consultation:

- ○ Weekly
- ○ Biweekly
- ○ Monthly
- ○ Other
- ○ In planning

Who is on the Review Team? Check all that apply.

- ○ Psychologist
- ○ Psychiatrist
- ○ Social worker
- ○ Physician
- ○ PA
- ○ APRN/NP
- ○ RN
- ○ LPN
- ○ Other Care Manager
- ○ Other (specify)
- ○ In planning

Identification and outreach to patients lost to follow up

- ○ Weekly
- ○ Biweekly
- ○ Monthly
- ○ Other
- ○ In planning

Who does outreach? Check all that apply.

- ○ Psychologist
- ○ Psychiatrist
- ○ Social worker
- ○ Physician
- ○ PA
- ○ APRN/NP
- ○ RN
- ○ LPN
- ○ Other Care Manager
- ○ MA
- ○ Other (specify)
- ○ In planning

8. What measures will you use to assess the integration of behavioral health and the impact of behavioral health services on your patient population? These might be measures of integration such as percentage of patients with a diagnosis of depression who are managed within the practice, key process measures such as percentage of patients with follow up within two weeks of initiating treatment, or measures of effective management, such as percentage of patients with depression who show improvement in scores on PHQ 9 over a period of time. (These are examples only and the identification of useful and effective measures for your practice will be a topic of the learning community.) *Text box will be provided.*

9. How have you increased your practice capacity to implement this program in the past quarter? (Drop down menu)
   - ○ Training (text box to specify)
   - ○ Hire or contract for new staff with BH skills *(text box to specify)*
   - ○ New referral or co-management arrangements *(text box to specify)*
   - ○ Other (text box to specify)
   - ○ None in this quarter

Reporting on Web Application for Self-Management Support [Quarters 2– 4]

1. What high-risk conditions (at least three) are the focuses for self-management support in your practice? How many patients in the practice have that condition? What triggers support for self-management?

   List conditions and number of eligible patients. *Text box will be provided.*

   List the triggers for each condition. Select all that apply.
   - ○ All patients with the condition
   - ○ General risk status (using the practice's risk stratification methodology)
   - ○ Poorly controlled disease
   - ○ Data from a formal self-management assessment tool
   - ○ Patient expression of interest
   - ○ Other (specify)

2. How do you provide your patients with disease or condition-specific skills for your target conditions (beyond patient education in the E/M visits with a physician, nurse practitioner or PA) and what are the training or credentials of the provider of disease or condition-specific skills? How many patients received training in managing their disease or condition this quarter?

Condition	Provided by (staff or external resource)	Training or credentials	Number of patients who received the intervention this quarter	
				◯ In planning
				◯ In planning
				◯ In planning
				◯ In planning

3. What cross-condition strategies does the practice use to support self-management and who is responsible?

Select the approaches and techniques. Select all that apply.

Between-visit planning and coaching

- ◯ Pre-visit development of a shared visit agenda with the patient.
- ◯ Team preparation for the patient.
- ◯ Coaching between visits and follow up on care plan and goals.

Goal setting and Care Plan/Action Plan development

- ◯ Discuss patient goals and document in EHR
- ◯ Develop care plan/action plan and document plan in the EHR

Peer support and counseling

- ◯ Peer-led support for self-management
- ◯ Group visits

Team members for each approach and technique. Select all that apply.

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

4. What approach are you using to assist patients in assessing their need for support for self-management? Select all that apply.
   - ◯ Patient Activation Measure (PAM)
   - ◯ How's My Health
   - ◯ Other (specify)
   - ◯ In planning

What evidence-based counseling approaches are you using in self-management support and who on the care team has the training for each selected approach? Select all that apply.

- ○ Motivational Interviewing
- ○ 5 As
- ○ Reflective Listening
- ○ Teach Back
- ○ Other

For each approach, who on the care team has the training? Select all that apply.

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

5. What specific self-management tools are you using and who on the team uses this tool? These can range from simple worksheets to help patients identify their agenda for a visit to web-based tools for the development of a shared care plan.

   List self-management tools you are using. *Text box will be provided.*

   For each tool listed, identify who on the team uses this tool.

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

6. What community-based resources do you make available to your patients for support for self-management and how do you link patients to this resource? Identify three to five community-based resources.
   - ○ In planning

   List community-based resources you make available to your patients. *Text box will be provided.*

   For each community-based resource, indicate how the link between the patient and the resource is made. Select one per resource.

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

7. How have you added to your practice capacity for support of self-management in the past quarter?
   - ○ Training (text box to specify)
   - ○ Hire or contract for new staff with specific training or skills (e.g., CDE) *(text box to specify)*
   - ○ Other (text box to specify)
   - ○ None in this quarter

8. What measures are you using to track the impact of support for self-management on care processes, health outcomes or costs for the conditions that you identified? Note that these can be the same measures tracked in Milestone 5.

Condition	Measure(s)

9. What new capacity have you developed in your practice this quarter in provision of support for self-management? *Text box will be provided.*

Select the means of adding each capacity. Select all that apply.

- ○ Hiring
- ○ Contracting
- ○ Formal relationship with external resource
- ○ Training of existing staff
- ○ Other

Reporting on Web Application for Medication Management [Quarters 2– 4]

1. What comprehensive medication management services does your practice provide? This should include medication reconciliation **and** additional services. Select all that apply.
   - ○ Medication reconciliation
   - ○ Coordination of medications across transitions of care settings and providers
   - ○ Medication review and assessment aimed at providing the safest and most cost-effective medication regimen possible to meet the patient's health goals
   - ○ Development of a medication action plan or contribution to a global care plan
   - ○ Medication monitoring
   - ○ Support for medication adherence and self-management
   - ○ Collaborative drug therapy management

2. How does your practice engage pharmacists as part of the care team and for how much time?
   - ○ Direct Hire
   - ○ System resource
   - ○ Contract
   - ○ Other agreement (specify)
   - ○ In planning

3. How many hours per week is the pharmacist engaged? *Text box will be provided.*

4. How does the pharmacist(s) on your team engage in patient care? Select all that apply.
   - ○ Pre-appointment review and planning without patient present
   - ○ Pre-appointment consultation and planning with patient
   - ○ Coincident referral ("warm hand-off") for consultation
   - ○ Follow-up referral from provider for appointment
   - ○ Medication review and recommendations in the EHR (asynchronous with visit)
   - ○ Specified medication management appointment or clinic (e.g., warfarin management or lipid management)
   - ○ E-consultations with patients through patient portal or other asynchronous communication
   - ○ Home visit
   - ○ As part of a group visit
   - ○ Other (specify)

5. How are patients selected for medication management services beyond routine medication reconciliation? These indications may be overlapping. Select all that apply.
   - ○ Based on risk cohorts (indicate which cohorts)
   - ○ Patients who have not achieved a therapeutic goal for a chronic condition (indicate the eligible conditions.)
   - ○ Patients with care transitions (indicate which transitions or any qualifying factors
   - ○ Patients with multiple ED visits or hospitalizations
   - ○ High risk medications
   - ○ Complex medication regimens
   - ○ Other (specify)

6. Does your practice provide Collaborative Drug Therapy Management?
   - ○ Yes

     For what conditions?
     - o Diabetes
     - o Hypertension
     - o Hyperlipidemia
     - o Anticoagulation
     - o Other
   - ○ No

     Indicate the reason for not providing this service by selecting one of the following:
     - o In planning
     - o Intend to do this but have not started yet
     - o Not supported by State Scope of Practice
     - o This is not a change we feel will significantly impact outcomes or care for our patients
     - o Other (indicate)

7. Does your practice target care transitions for comprehensive medication management services?
   - ○ Yes

     What triggers these services? Check all that apply.
     - o ED visit
     - o Hospital admission
     - o Hospital discharge
     - o NF or SNF admission
     - o NF or SNF discharge
     - o Referral
     - o Other

     Who receives these services?
     - o All patients
     - o Patients with specific risk factors (specify)

   - ○ No

     Indicate the reason for not providing this service by selecting one of the following:
     - o In planning
     - o Intend to do this but have not started yet
     - o We address medication review, management, and coordination in this high risk period in a different way (specify how)

8. What process measures does your practice use to improve medication effectiveness and safety? *Text box will be provided.*

Milestone 3: 24/7 Access by Patients and Enhanced Access

The work in Milestone 3 addresses access to care beyond the office visit. In PY 2013 you ensured 24/7 access to care guided by the patient's information in the EHR. In PY 2014 you will improve patients' access to care through providing opportunities for consulting with their provider or care team outside of office visits.

24/7 Access by Patients [Quarterly, X]

Your practice will attest to the completion of the PY 2013 requirements. In PY 2013, all practices were asked to ensure that patients had 24/7 access to a care team practitioner who had real-time access to their electronic medical record. This could be provided by a care team member for your practice or through various coverage arrangements.

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

- ○ Yes
- ○ No

If the answer is No, then when does your practice expect to have 24/7 access to your EHR for all practitioners covering calls after patient hours?

- ○ Within 3 months
- ○ Between 3 and 6 months
- ○ More than 6 months

Enhanced Access Outside of Office Visits [Quarterly, X]

Please tell us how your practice is providing enhanced patient access (care provided to patients outside of office visits). Select all that apply.

- ○ Patient portal messages
- ○ Email
- ○ Text messaging
- ○ Structured phone visits
- ○ Other (text box will be provided)
- ○ In progress/we are currently building this capacity

Staff Time Spent on Care Provided Outside of Visits [Quarterly, #]

On average, about how many hours per week does staff spend on care provided to the patient outside of office visits? Please complete the table below. Enter "0" if your practice does not have the specific staff category. Estimate the total hours **per week for each quarter**. Use whole numbers only with no decimals.

	Number of staff in category	**Estimated hours per week in Quarter 1**	**Estimated hours per week in Quarter 2**	**Estimated hours per week in Quarter 3**	**Estimated hours per week in Quarter 4**
Physician					
PA					
APRN/NP					
RN					
LPN					
MA					
Health Educator					
Behavioral Health Professional					
Administrative					
Pharmacist					
Other, specify:					
Other, specify:					

Commitment to Timely Responses [Quarterly, X]

Enhanced access or care provided outside of normal office hours is a new concept for patients and their families. This new concept needs to be communicated to patients. Your practice will indicate how the information about enhanced access is communicated to patients and their families:

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

- ○ Poster in office
- ○ Hand-out given to patient in office
- ○ Website
- ○ Mailing to patients
- ○ Other (text box will be provided)

Milestone 4: Improve Patient Experience

The work in Milestone 4 puts the patient and family at the center of care, using the Patient and Family Advisory Council and brief, in-office surveys to understand your patient's perspective and improve the experience of care.

Patient Experience Option Selection [Quarter 1, X]

In Quarter 1, your practice will select the assessment method(s) that will be used *(please note: this selection cannot be changed in subsequent quarters)*:

- ○ Option A: Conduct monthly practice-based survey
- ○ Option B: Patient and Family Advisory Council (PFAC) that meets quarterly
- ○ Option C: Office-based surveys administered quarterly and PFAC convened semi-annually

Option A: Conduct practice-based survey monthly

By selecting Option A, your practice will be responsible for developing and sharing an improvement plan designed to improve measures of patient experience in identified areas, which are targeted for improvement. You will need to administer a monthly patient experience survey. The survey questions should be the same each month so that you can see trends.

CAHPS-Domains [Quarterly, X]

Identify at least two CAHPS-PCMH domains for improvement that your practice will focus on in its survey Select all that apply.

- ○ Access
- ○ Communication
- ○ Coordination of Care
- ○ Self-management Support
- ○ Shared Decision Making

Distribution of Patient Survey [Quarterly, X]

Identify the methods that your practice used to administer the quarterly patient survey. Select all that apply.

- ○ Distributed and collected during office visit
- ○ Practice mailed to patients
- ○ Practice called patients
- ○ Practice administered online survey tool (e.g., Survey Monkey)
- ○ Distributed via Patient Portal
- ○ Used a survey vendor
- ○ Other (text box will be provided)

Survey Results and Improvement Process [Quarterly, N]

Provide a brief description of the survey results for this quarter and the actions that your practice is taking to address areas of improvement. A text box will be provided.

Communication of Survey Results [Quarterly, X]

Indicate how your practice is communicating the survey results and demonstrating its commitment to integrating the patient voice into the practice from the following selections. Select all that apply.

- ○ Posted in office
- ○ Brochure or other communication provided to patient in office
- ○ Website
- ○ Brochure or other communication mailed to patients
- ○ Other

Option B: PFAC that meets quarterly

By selecting Option B, your practice will form a Patient and Family Advisory Council, which will meet on a quarterly basis.

Area of Focus [Quarterly, X]

Identify the area(s) of focus for Patient and Family Advisory Council involvement in your practice transformation activities from the following selections. Select all that apply.

- ○ Access
- ○ Communication
- ○ Coordination of Care
- ○ Self-management Support
- ○ Shared Decision Making

PFAC Composition [Quarterly, N]

Identify the composition of your Patient and Family Advisory Council below:

Role	Number of Individuals
Physician	
PA	
APRN/NP	
RN	
LPN	
MA	
Behavioral Health Professional	
Health Educator	
Pharmacist	
Patient	
Family/Caregiver	
Hospital Representative	
Administrative	
Other (practices will be able to added up to 5 additional roles)	

PFAC Meeting Dates [Quarterly, X, N]

Identify the date of your practice's quarterly PFAC meeting. Calendar provided.

- ○ Our PFAC did not meet this quarter.

  Please explain why your PFAC did not meet. (Text box will be provided.)

Communicating the Role of the PFAC [Quarterly, X]

Indicate how your practice is communicating the role of the PFAC to the patients in your practice and how your practice is demonstrating its commitment to integrating the patient voice into your practice environment. Select all that apply.

- ○ Posted in office
- ○ Brochure or other communication provided to patient in office
- ○ Website
- ○ Brochure or other communication mailed to patients
- ○ Other (text box provided)

Option C: Office based surveys administered quarterly and PFAC convened semi-annually

By selecting Option C, your practice will administer a quarterly patient-based survey, which is designed to improve measures of patient experience in identified areas that are targeted for improvement. The survey questions should be the same each quarter so that you can track trends. Additionally, your practice will convene a Patient and Family Advisory Council twice a year.

CAHPS-Domains [Quarterly, X]

Identify at least two CAHPS-PCMH domains for improvement that your practice will focus on in its survey. Select all that apply.

- ○ Access
- ○ Communication
- ○ Coordination of Care
- ○ Self-management Support
- ○ Shared Decision Making

Distribution of Patient Survey [Quarterly, X]

Identify the methods that your practice used to administer the quarterly patient survey. Select all that apply.

- ○ Distributed and collected during office visit
- ○ Mailed to patients
- ○ Called patients
- ○ Administered online survey tool (e.g., Survey Monkey)
- ○ Distributed via Patient Portal
- ○ Used a survey vendor
- ○ Other (text box provided)

Survey Results and Improvement Process [Quarterly, N]

Provide a brief description of the survey results for this quarter and the actions that your practice is taking to address areas of improvement. *Text box will be provided.*

Communication of Survey Results [Quarterly, X]

Indicate how your practice is communicating the survey results and demonstrating its commitment to integrating the patient voice into the practice from the following selections. Select all that apply.

- ○ Posted in office
- ○ Brochure or other communication provided to patient in office
- ○ Website
- ○ Brochure or other communication mailed to patients
- ○ Other (text box provided)

Area of Focus [Quarterly, X]

Identify the area(s) of focus for Patient and Family Advisory Council involvement in your practice transformation activities from the following selections. Select all that apply.

- ○ Access
- ○ Communication
- ○ Coordination of Care
- ○ Self-management Support
- ○ Shared Decision Making

PFAC Composition [Quarterly, N]

Identify the composition of your Patient and Family Advisory Council below:

Role	Number of Individuals
Physician	
PA	
APRN/NP	
RN	
LPN	
MA	
Behavioral Health Professional	
Health Educator	
Pharmacist	
Patient	
Family/Caregiver	
Hospital Representative	
Administrative	
Other (practices will be able to added up to 5 additional roles)	

PFAC Meeting Dates [Quarterly, X, N]

Identify the date of your practice's semi-annual PFAC meeting. Calendar provided.

- ○ Our PFAC did not meet this quarter.

Please explain why your PFAC did not meet. *(Text box will be provided.)*

Communicating the Role of the PFAC [Quarterly, X]

Indicate how your practice is communicating the role of the PFAC to the patients in your practice and how your practice is demonstrating its commitment to integrating the patient voice into your practice environment

Select all that apply.

- ○ Posted in office
- ○ Brochure or other communication provided to patient in office
- ○ Website
- ○ Brochure or other communication mailed to patients
- ○ Other (text box will be provided)

Milestone 5: Use Data to Guide Improvement

Milestone 5 is intended to help you take a systematic approach to using data from your practice and about your practice to improve care. In the PY 2013, you identified measures for quality and utilization that are important to your practice and your patients, and used that measure as a guide while you test changes in your practice. In PY 2014 the work in this milestone supports your continued work to improve quality of care as measured by the CPC Clinical Quality Measures.

Monitoring Practice-Level Quality [Quarters 2 – 4, X]

Your practice should review *all CPC CQMs* for your entire practice site on a regular basis. Identify how often your practice is reviewing **all** CPC CQMs for the practice site.

- ○ Weekly
- ○ Monthly
- ○ Quarterly
- ○ Our EHR cannot support practice site level reports

Making EHR Data Available [Quarters 2 – 4, X]

Identify who in your practice does the work of making data from the EHR available to guide and inform efforts to improve care and utilization, either on a systematic basis (provider or practice quality or utilization reports) **or to answer a specific question that might arise** (e.g., "Who are my patients with an A1C greater than 9.0%?"). Select all that apply.

- ○ Dedicated data analyst(s)
- ○ Medical records staff
- ○ Clinic Manager
- ○ Physician
- ○ PA
- ○ APRN/NP
- ○ RN
- ○ LPN
- ○ MA
- ○ Other Care Manager
- ○ Other (text box provided)

Improving Quality at the Practitioner/Care Team Level [Quarterly, X]

Your practice should regularly create individual practitioner or care team CQM reports. Identify how often your practice's individual practitioners and/or care teams review **panel-specific** CQM data.

- ○ Weekly
- ○ Monthly
- ○ Quarterly
- ○ Our practice cannot create panel-specific CQM reports

Focus on Quality Improvement Activities [Quarters 2 – 4, X]

For this Milestone, your practice is required to provide practitioner or care team reports on at least three measures at least quarterly to support improvement in care. In this past quarter, for which quality measures did your practitioner(s) or care team(s) focus their quality improvement activities? Select all that apply.

Table 1. Clinical Quality Measures

CMS ID & Ver.	NQF #	Clinical Quality Measure Title	Required in 2013	Required in 2014 & 2015	Domain
165v2	0018	Controlling High Blood Pressure	Yes	Yes	Clinical Process/ Effectiveness
138v2	0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Yes	Yes	Population/ Public Health
125v2	0031	Breast Cancer Screening	Yes	Yes	Clinical Process/ Effectiveness
130v2	0034	Colorectal Cancer Screening	Yes	Yes	Clinical Process/ Effectiveness
147v2	0041	Preventive Care and Screening: Influenza Immunization	Yes	Yes	Population/ Public Health
122v2	0059	Diabetes: Hemoglobin A1c Poor Control	Yes	Yes	Clinical Process/ Effectiveness
163v2	0064	Diabetes: Low Density Lipoprotein (LDL) Management	Yes	Yes	Clinical Process/ Effectiveness
182v3	0075	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control	Yes	Yes	Clinical Process/ Effectiveness
144v2	0083	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Yes	Yes	Clinical Process/ Effectiveness
139v2	0101	Falls: Screening for Future Fall Risk	No	Yes	Patient Safety
2v3	0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	No	Yes	Population/ Public Health

Milestone 6: Care Coordination Across the Medical Neighborhood

The work in Milestone 6 is to develop systematic coordination of care across the medical neighborhood. In CPC PY 2013 you reached out for willing partners. In CPC PY 2014 you will take a more systematic approach, working with hospitals, emergency departments, and specialists to close the seams of care for your patients as they transition between settings and providers.

Identify Area of Improvement [Quarter 1, X]

Building on your practice's PY 2013 activities, select *two* of the care coordination options below. *Please note: The selection made in Quarter 1 cannot be changed in subsequent quarters.*

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

Option A: Follow-up contact with patient within One Week of ED Discharge (Quarters 2 – 4)

The CPC goal for care coordination across the medical neighborhood is that your practice tracks the number of patients who received a follow-up contact from your practice within one week of discharge from a target emergency department (ED). A target ED is defined as a facility for which your practice can receive regular and timely information about your patient population's ED discharges. Your practice should contact patients within one week of discharge from the ED.

In the table below, identify the EDs of focus and the counts for tracking your practice's follow-up correspondence with patients discharged from the ED. Estimate these counts, if necessary.

Numerator: Number of your patients that received a follow-up contact after ED discharge within one week

Denominator: Number of your patients discharged from the target ED during this quarter

Name of ED	Numerator	Denominator

Methods for Obtaining ED Information [Quarterly, X]

Identify the methods that your practice uses for obtaining ED discharge information. Select all that apply.

- ○ Phone
- ○ Fax
- ○ Email
- ○ Health Information Exchange (HIE)
- ○ Other (text box will be provided)

Option B: Follow-up Contact within 72 Hours of Hospital Discharge (Quarters 2 – 4)

The CPC goal for care coordination across the medical neighborhood is that your practice contact at least 75% of patients within 72 hours of discharge from one or more target hospital(s). A target hospital is defined as a facility from which your practice can receive regular and timely information about your patient population's hospitalizations.

In the table below, identify the hospital(s) of focus and the counts for tracking your practice's follow-up contact with discharged patients. Estimate these counts, if necessary.

Numerator: Number of your patients who received follow-up contact within 72 hours after discharge
Denominator: Number of your patients discharged from the target hospital during this quarter

Name of Hospital	Numerator	Denominator

Methods for Obtaining Hospital Discharge Information [Quarterly]

Identify the methods that your practice uses for obtaining hospital discharge information. Select all that apply.

- ○ Phone
- ○ Fax
- ○ Email
- ○ Health Information Exchange (HIE)
- ○ Other (text box will be provided)

Option C: Care Compacts/Agreements with At Least Two High Volume Specialists (Quarters 2 – 4)

Your practice indicated that it has enacted Care Compact and Agreements **with at least two groups of high-volume specialists in different specialties in order to improve the coordination and transitions of care for your patient population.** Identify the specialist types with whom you have arranged these care compacts/ collaborative agreements. Select all that apply and select at least two from the following options:

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

Please note: Retain a copy of the signed care compacts/collaborative agreements that your practice has with the high-volume specialists in your community.

Milestone 7: Shared Decision Making

*The work in Milestone 7 is to support patients to be engaged, informed and effective partners in their own health care. Through the work in Milestone 7 you will be exploring the **use of decision aids** to **support shared decision making** between providers and patients in **preference-sensitive care**. In CPC PY 2013 you tested a decision aid as a way to engage patient in shared decision making. In CPC PY 2014 you will add additional aids and achieve increased use of these aids as you engage patients and families in making important decisions about their health.*

Area of Priority [Quarter 1, X]

Identify at least TWO health conditions, decisions, or tests of focus for which your practice is implementing shared decision making. Select two to five options.

The following list contains some common preference-sensitive conditions for your practice to consider. Ideally, your practice is focusing on an area that is important to the patients in your practice and for which you can acquire an aid/tool.

- ○ Management of acute low back pain (without red flags)
- ○ Antibiotic overuse for upper respiratory infection
- ○ Anticoagulation in atrial fibrillation
- ○ Management of anxiety or depression
- ○ Management of asthma
- ○ Cataract surgery
- ○ Management of chronic back pain
- ○ Management of chronic pain
- ○ Management of congestive heart failure
- ○ Management of COPD
- ○ Medications in diabetes
- ○ Joint replacement
- ○ Podiatric surgery
- ○ PSA for prostate cancer screening
- ○ EKG and cardiac stress testing
- ○ Care preferences over the life continuum
- ○ Colon cancer screening
- ○ Management of heart failure
- ○ Management of coronary heart disease
- ○ Management of Peripheral Artery Disease (PAD)
- ○ Managing health concerns of older adults
- ○ Menopause
- ○ Urinary incontinence
- ○ Knee osteoarthritis

Other (The following are additional preference-sensitive conditions that can be considered but are not listed on the webapp. Note that this list is not all inclusive.):

- ○ Chronic, Stable Angina
- ○ Management of Heavy Menstrual Bleeding
- ○ Management of Carpal Tunnel Syndrome
- ○ Management of Middle Ear Fluid
- ○ Hip osteoarthritis
- ○ Management of Psoriasis
- ○ Management of Trigger Finger
- ○ Lung cancer screening in smokers
- ○ Management of Benign Prostatic Hyperplasia
- ○ Management of tobacco cessation
- ○ Management of Obesity

Source of Decision Aid [Quarterly, X]

For the priority area selected above, please identify the producers of the decision aids that your practice will use.

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

Rate of Use [Quarterly, #]

For each area of priority selected, indicate the counts or percentage of eligible patients who received a decision aid for the selected area of focus. This rate should increase over time as your practice works to implement this decision aid.

Please select your preference for reporting:

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

For practices who chose to report as a count:

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Number of eligible patients who received a decision aid				

For practices who chose to report as a rate:

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Percent of eligible patients who received the decision aid				

Milestone 8: Participation in the CPC Learning Collaborative [Quarter 4, X]

Milestone 8 captures the work involved in participation in both your region's learning collaborative and in the national community of CPC practices; each practice has a responsibility to actively engage and share in the learning with other practices, regionally and nationally. For each activity below, practices will attest to whether your practice met the requirements for participation. If your practice was not able to complete one or more of the activities, please indicate the reason in the Reason Fields below.

Participate in all three all-day CPC learning sessions in your region.

- ○ Our CPC Practice Site participated in the above activities during Program Year 2014.
- ○ Our CPC Practice Site DID NOT participate in the above activities during Program Year 2014. *Text box provided for explanation.*

Participate in at least one learning webinar per month.

- ○ Our CPC Practice Site participated in the above activities during Program Year 2014.
- ○ Our CPC Practice Site DID NOT participate in the above activities during Program Year 2014. *Text box provided for explanation.*

Contribute a minimum of one document of experiential story to the CPC Collaboration Website or the CPC Spotlight.

- ○ Our CPC Practice Site participated in the above activities during Program Year 2014.
- ○ Our CPC Practice Site DID NOT participate in the above activities during Program Year 2014. *Text box provided for explanation.*

Fully engage with the Regional Learning Faculty, including by providing regular status information as requested, for the purposes of monitoring progress toward Milestone completion and/or for the purposes of providing support to meet the Milestones.

Select one:

- ○ Our CPC Practice Site participated in the above activities during Program Year 2014.
- ○ Our CPC Practice Site DID NOT participate in the above activities during Program Year 2014. *Text box provided for explanation.*

Upon attestation, you will be asked to provide your name, your position with the practice site and the date.

Milestone 9: Health Information Technology

Demonstrating achievement of Milestone 9 requires that practices participate in the CMS Meaningful Use Incentives program, using this program as a framework for optimal use of your electronic health record in the care of patients.

Use of ONC-certified EHR [Quarter 1, X]

Your practice must adopt and use EHR technology that has been certified in accordance with the Office of the National Coordinator for Health IT's (ONC) 2014 Edition EHR Certification Criteria. Please select one of the options below.

- ○ Yes, we are using a 2014 version or later ONC-certified EHR
- ○ No, we are not using a 2014 version or later ONC-certified EHR

Exchange Health Information Electronically [Quarters 2 – 4, X]

The ability to exchange health information electronically is emerging in many CPC regions offers and your practice a powerful tool for providing comprehensive primary care while improving care and health outcomes at lower cost. Please indicate with which settings you are able to securely exchange patient information. Select all that apply.

- ○ Acute care hospital/Emergency Department
- ○ Urgent care center
- ○ Rehabilitation hospital
- ○ Specialty hospital
- ○ Skilled nursing facility
- ○ Other long-term care facility
- ○ Ambulatory surgery center
- ○ Other health clinics/physician offices
- ○ Home health/hospice
- ○ Public health department
- ○ Pharmacy

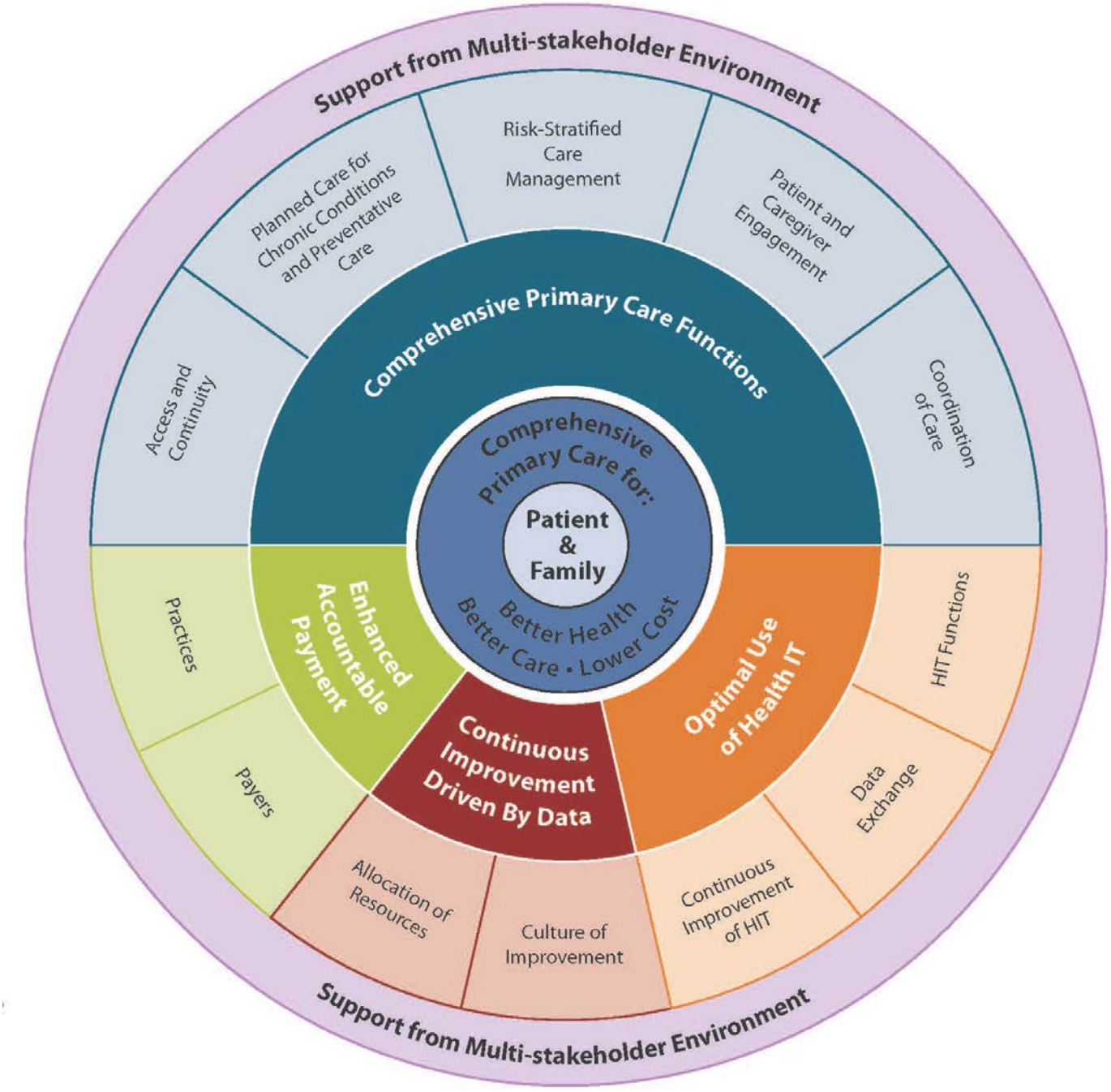
Meaningful Use [Quarter 4, X]

Your practice attests that all eligible professionals (EPs) at this practice site have achieved Meaningful Use in accordance with the requirements of the EHR Incentive Program. Please select one of the options below.

- ○ Yes, all our EPs are Meaningful Users.
- ○ No, not all of our EPs are Meaningful Users. *(Text box will be provided for explanation.)*

Comprehensive Primary Care Initiative Change Package

Below is an illustration of the "logic model" for the CPC initiative, and following it is the Change Package, which delineates the concepts and tactics that support the aim of CPC: better health, better care and lower cost.



Primary Driver – 1.0 Comprehensive Primary Care Functions

Table 2: Secondary Driver 1.1 Access and Continuity

SECONDARY DRIVER	CHANGE CONCEPT	CHANGE TACTICS
1.1 Access and Continuity	A: Optimize timely access to care guided by the medical record.	Provide 24/7 access to provider or care team for advice about urgent and emergent care, for example: • Provider/Care Team with access to medical record • Cross-coverage with access to medical record • Protocol-driven nurse line with access to medical record
		Expanded hours in evenings and weekends with access to the patient medical record (e.g. coordinate small practices to provide alternate hours office visits and urgent care)
		Provide same-day or next day access when needed for urgent care or transition management
		Provide alternative points of access such as: • E-visits • Phone visits • Group visits • Home visits • Alternate locations (e.g. senior centers, assisted living centers) • Patient portal for e-access to information
	B: Empanel all patients to a care team or provider.	Empanel (assign responsibility for) the total population, linking each patient to a provider or care team.
	C: Optimize continuity with provider and care team.	Ensure that patients are able to see their provider or care team whenever possible

Table 3: Secondary Driver 1.2 Planned Care for Chronic Conditions and Preventive Care

SECONDARY DRIVER	CHANGE CONCEPT	CHANGE TACTICS
1.2 Planned Care for Chronic Conditions and Preventive Care	A: Use a personalized plan of care for each patient. B: Manage medications to maximize therapeutic benefit and patient safety at lowest cost.	Provide all patients annually with an opportunity for development of an individualized health plan, including health risk appraisal, gender, age, and condition-specific preventive care services, chronic condition management, and advance care planning.
		Integrate patient goals and priorities into plan of care.
		Use the Medicare *Annual Wellness Visit with Personalized Prevention Plan Services* (AWV with PPPS) for Medicare patients.
		Provide medication reconciliation at each relevant encounter.
		Conduct a periodic, structured, medication review.
	C: Proactively manage chronic and preventive care for empanelled patients.	Use age, gender, and condition-specific protocols and proactive, planned care appointments for chronic conditions and preventive care services.
		Use panel support tools (registry functionality) to identify services due.
		Use reminders and outreach (e.g., phone calls, emails, postcards, community health workers where available) to alert and educate patients to services due.
	D: Use team-based care to meet patient needs efficiently.	Define roles and distribute tasks among care team members, consistent with the skills, abilities, and credentials of team members to better meet patient needs.
		Use decision support and protocols to manage workflow in the team to meet patient needs.
		Manage workflow to address chronic and preventive care, for example through pre-visit planning or huddles.
		Integrate behavioral health services into primary care.
		Integrate interdisciplinary team members, e.g., Nutrition, Behavioral Health, Pharmacy, PT into primary care.

Table 4: Secondary Driver 1.3 Risk-Stratified Care Management

SECONDARY DRIVER	CHANGE CONCEPT	CHANGE TACTICS
1.3 Risk-Stratified Care Management	A: Assign and adjust risk status to each patient.	Use a consistent method to assign and adjust global risk status for all empanelled patients to allow risk stratification into actionable risk cohorts.
	B: Use care management pathways appropriate to the risk status of the patient.	Use on-site practice-based or shared care managers to proactively monitor and coordinate care for the highest risk cohort of patients.
		Use panel management and registry capabilities to support management of patients at low and intermediate risk.
	C: Manage care across transitions.	Formalize lines of communication with local care settings in which empanelled patients receive care to ensure documented flow of information and clear transitions in care.
		Actively manage transitions in care for high risk patients.
		Partner with community or hospital-based transitional care services.
		Provide a current list of medications for hospitalized as soon as possible following admission.
	D: Use evidence-based pathways for care.	Use standard care pathways for common conditions (e.g. depression, asthma, heart failure) with evidence-based triggers for consultation.
		Identify standard care pathways for common conditions responsible for preventable hospitalizations and ED visits.

Table 5: Secondary Driver 1.4 Patient and Caregiver Engagement

SECONDARY DRIVER	CHANGE CONCEPT	CHANGE TACTICS
1.4 **Patient and Caregiver Engagement**	A: Integrate culturally competent self-management support into usual care.	Incorporate evidence-based techniques to promote self-management into usual care, using techniques such as goal setting with structured follow-up, Teach Back, action planning, or Motivational Interviewing.
		Provide self-management materials at appropriate literacy level and in appropriate language.
		Provide chronic disease self-management support programs or link to those programs in the community. Examples include: • Telephonic smoking quitlines • Alcoholics Anonymous • Day programs for substance abuse • Cardiac or pulmonary rehabilitation programs • Other state and national programs
	B: Involve patient and family in decision-making in all aspects of care.	Use evidence-based decision aids to provide information about risks and benefits of care options.
		Routinely share lab results with appropriate education.
		Routinely discuss goals of care.
		Engage patients, family and caregivers in developing plan of care and prioritizing their goals for action.
	C: Engage patients and families to guide improvement in the system of care.	Regularly assess the patient experience of care through survey, focus groups or other mechanisms.
		Engage patients and families in practice re-design (patient advisory boards for example).

Table 6: Secondary Driver 1.5 Coordination of Care

SECONDARY DRIVER	CHANGE CONCEPT	CHANGE TACTICS
1.5 Coordination of Care	A: Ensure patient information necessary to provide care is available across the medical neighborhood.	Formalize lines of communication with local care settings in which empanelled patients receive care.
		Establish care coordination agreements with urgent and emergent care settings to clarify respective responsibilities.
		Establish mechanisms for appropriate sharing of patient information to guide care decisions (e.g. through health information exchanges or using the personal health record or routine, structured referral notes).
		Establish care coordination agreements with frequently used consultants that set expectations for documented flow of information and provider expectations between settings.
	B: Use community-based resources to support patient health goals.	Link to community-based chronic disease self-management support programs, exercise programs and other wellness resources.
		Document availability of community resource guide for patient self-management support.

Primary Driver – 2.0 Enhanced Accountable Payment

Table 7: Secondary Drivers 2.1 – 2.2 Practices and Payers

SECONDARY DRIVER	CHANGE CONCEPT	CHANGE TACTICS
2.1 Practices	A: Use budgeting and accounting processes effectively to transform care processes.	Invest new revenue in priority areas for practice transformation.
		Use accounting and budgeting tools and processes to allocate new revenue.
		Develop benchmarking and analytic capacity to maximize likelihood of shared savings.
	B: Create value and support processes of care that align with better health, better care and lower costs through improvement.	Use productivity measures that include non-visit related care.
		Incent effective team-based care through non-visit based payment.
2.2 Payers	A: Use population-based payment to purchase comprehensive primary care services.	Prospectively align every member or beneficiary with a primary care provider or practice.
		Provide a per-member or beneficiary per-month supplement to fee for services for comprehensive primary care services.
		Risk adjust per member or beneficiary per month payment based on transparent methodology, shared with the practices.
		Align standards for Comprehensive Primary Care services.
	B: Provide actionable, timely, cost and utilization data to practices.	Provide at least quarterly reports of timely data, by provider and practice, of services received by beneficiaries from outside of the primary care practice.
		Notify providers and practices of ER visits and admissions, as soon as possible.
		Provide an annual report of cost for services by providers in the medical neighborhood of the primary care practice.
	C: Reward provider attention to total cost of care.	Use a shared savings or similar methodology tied to the reports you are sharing.
	D: Align quality, cost and utilization measures.	Seek alignment of measures for quality of care, patient experience, and cost of care with CMS and other major payers in their market.

Primary Driver – 3.0 Continuous Improvement Driven by Data

Table 8: Secondary Drivers 3.1 – 3.2 Allocation of Resources and Culture of Improvement

SECONDARY DRIVER	CHANGE CONCEPT	CHANGE TACTICS
3.1 Allocation of Resources	A: Allocate resources to support continuous improvement driven by data.	Train appropriate staff on interpretation of total cost of care Information.
	B: Use available data to guide improvement.	Identify a small set of clinical quality and utilization measures that are meaningful to the practice team. Acquire or implement capacity to monitor practice and panel performance using these measures to guide practice improvement.
		Compare the practice providers' performance to each other and compare the overall practice performance to that in the community.
		Enable report creation from data in the EHR and/or practice management system.
3.2 Culture of Improvement	A: Adopt a formal model for quality improvement.	Train staff in quality improvement methods.
	B: Create a culture in which everyone actively participates in improvement activities.	Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience, and utilization data with staff.
		Promote transparency and engage patients and families by sharing practice level quality of care, patient experience, and utilization data with patients and families.
		Designate regular team meetings to review data and plan improvement cycles.
	C: Active participation in transformation collaborative	Engage with other practices with transparent sharing of common metrics to guide practice change.
		Share successful practice changes and materials with other practices.
		Access expertise to assist in practice changes of strategic importance to the practice.

Primary Driver – 4.0 Optimal Use of Health IT

Table 9: Secondary Drivers 4.1 – 4.3 HIT Functions, Data Exchange and Continuous Improvement of HIT

SECONDARY DRIVER	CHANGE CONCEPT	CHANGE TACTICS
4.1 HIT Functions	A: Use a certified electronic health record.	Develop or activate the following capabilities: • Templates to embed decision support into care and capture key clinical data • Panel-level and practice-level reports to guide improvement in care and practice transformation • Registry functions, reminders and alerts to support proactive care and care management of high-risk patients • A patient portal to support patient and family engagement in care • Secure email
4.2 Data Exchange	A: Enable the flow of patient information to support care.	Connect to local health information exchanges if available.
		Develop information exchange processes and agreements with other service providers with which the practice shares patients.
		Use standard documents created by the EHR routinely to share information (including, e.g., med lists, problem lists, allergies, goals of care documents, etc.) at time of referral or institutional transition.
		Use delegated, non-clinician workflows for entering structured clinical data from external (e.g., paper, e-fax) source.
4.3 Continuous Improvement of HIT	A: Continuously improve function and use of the electronic health record.	Develop a process for continuous improvement of EHR use through identification of priorities and testing and implementation of new functions.
		Convene regularly to discuss and improve workflows to optimize use of the EHR.
	B: Hire/train staff to develop, maintain, and improve EHR function.	Cross-train staff members in key skills in the use of HIT to improve care.
		Hire, contract or designate staff whose role is continuous improvement of EHR through redesign of workflows and optimal use of existing functionality.

CPC Tools and Resources

General Resources

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

Resources for Milestone 1: Budget

Tools and Resources

Budget Milestone Step 1: Budget Spreadsheet Initial Submission
The CPC budget tool is an Excel spreadsheet practices should complete with information regarding their PY 2013 CPC funds and the investments they make in their practice.

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

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

Webinars

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

CPC Budget Submission, New York Learning Session, Feb. 21, 2013 (28-page PDF)
This presentation describes how to prepare the practice's CPC budget for the first Program Year budget submission.

CPC Budgeting, An Exercise in Strategic Planning, New York Learning Session, Dec. 13, 2012 (24-page PDF)
This presentation describes how to plan the practice's CPC budget for the first Program Year budget submission.

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

PY 2014 Curriculum Overview and Milestone 1: Budget, National Webinar, Jan. 14, 2014 (33-page PDF, transcript and video)
This presentation focuses on PY 2014 curriculum and budget for PY 2013 and PY 2014.

Milestone 1: Budget Reporting and Budget as a Planning Tool, Regional Webinar, Jan. 24, 2014 (36-page PDF)
This presentation focuses on reconciling PY 2013 costs and revenue, PY 2014 budget forecasting and submission and work plans and thought processes for forecasting PY 2014 budget.

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

Care Management Tools and Resources

Care Management in CPC

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

IHI: Chronic Care Management

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

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

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

Sample Care Plan Templates, Colorado Regional Webinar Resource (10 sample care plans)

This posting includes 10 sample care plan template examples and assessment referred to in the CO regional webinar on March 20, 2014, on patient engagement and care plans.

Care Management Webinars

Care Management, Oregon Learning Session, Dec. 20, 2012 (40-page PDF)

An overview of care management strategies, starting with who will provide the service and working through issues practices need to address as they operationalize.

Complex Care Management, Colorado Learning Session, March 8, 2013

This webinar describes high-risk care management, how it works and how practices can get started.

Coordinated Systems of Care, New York Learning Session, Jan. 24, 2013 (50-page PDF)

This webinar summarizes the common perspectives of coordinated care, strategies for formation of a comprehensive care team, strategy for delivery of case/care management.

Health Disparities – Equity and Care Management, National Webinar, Feb. 26, 2014 (30-page PDF, transcript and video)

This presentation focuses on care management and equity, patient coaching, proactive care delivery, identifying a care manager and stories from the field: Duke University. The one-page resource document includes websites and other resources with further information on health issues among minority populations.

Introduction to New Primary Care Strategies for Milestone 2, National Webinar, Jan. 28, 2014 (32-page PDF, transcript and video)

Webinar focuses on three primary care strategies for PY 2014: Self-Management Support, Integrated Behavioral Health and Comprehensive Medication Management.

Sample Care Plan Templates, Colorado Regional Webinar Resource (10 sample care plans)

This posting includes 10 sample care plan template examples and assessment referred to in the Colorado regional webinar on March 20, 2014, on patient engagement and care plan.

Empanelment Tools

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

Risk Stratification Tools and Resources

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

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

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

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

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

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

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

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

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

Risk Stratification Process (2-page PDF)
Risk stratification method using four levels, which correspond to primary, secondary and tertiary prevention as levels 1, 2 and 3. The 4th level is the patient who is a vastly complicated and high-risk individual.

Risk Stratification Webinars

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

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

Risk-Stratified Care Management, AR/OK Learning Session, Dec. 21, 2012
This presentation provides steps toward starting a risk stratification care management plan as well as what to avoid. Comprehensive notes for this session are provided here as well.

Behavioral Health Integration Tools and Resources

CPC Practice Spotlight – Oregon Medical Group, March 7, 2014 (3-page PDF)
Article features a Eugene, Oregon, practice with embedded behavioral specialists.

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

Behavioral Health Integration Webinars

Advanced Primary Care: The Role of Behavioral Health on the Primary Care Team, National Webinar, March 18, 2014 (30-page PDF, transcript and video)
This presentation focuses on Milestone 2, the role of behavioral health on the primary care team.

Medication Management Tools and Resources

CPC Practice Spotlight – OU Physicians and Associates in Family Medicine, March 21, 2014 (3-page PDF)
Article features CPC practices Associates in Family Medicine in Colorado and OU Physicians in Oklahoma sharing how their pharmacists contribute not only to medication management but also to quality improvement, patient satisfaction and timely care.

Self-Management Tools and Resources

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

Resources for Milestone 3: 24/7 Access by Patients and Enhanced Access

Tools and Resources

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

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

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

Webinars

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

Resources for Milestone 4: Patient Experience

Tools and Resources

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

CAHPS-Related Items

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

CAHPS survey: "Evaluation of the Comprehensive Primary Care Initiative" (12-page PDF)
This survey was sent to patients of CPC practices in May 2013.

Cover Letter for the CAHPS Survey (2-page PDF)
CMS' cover letter to patients describing the CAHPS survey; in English and Spanish.

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

Practice Talking Points for Patients with Questions about the Patient Survey (3-page PDF)
This document contains the Comprehensive Primary Care (CPC) initiative talking points to engage patients and help answer questions patient could ask about the patient surveys.

Improving Patient Experience of Care Resources, Links to two Robert Wood Johnson Foundation resources on improving patient experience of care resources

Resources were addressed during the National Webinar on CAHPS on March 11, 2014. Resource link 1 is an inventory and lists a variety of free resources—including toolkits, guides, reports and webcasts—that are available to support health care organizations in determining what they need to do to improve patient experience and how to implement those improvements. Resource link 2 is a list for Improving Patient Experience of Care.

Webinars

National Partnership for Women & Families Webinar Series

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

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

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

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

Resources for Milestone 5: Quality Improvement

Tools and Resources

AHRQ: Uses of Quality Measures

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

IHI Open School Run Chart Tool

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

Webinars

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

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

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

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

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

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

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

Resources for Milestone 6: Care Coordination Across the Medical Neighborhood

Tools and Resources

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

Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanisms (45-page PDF)
Describes mechanisms of communication between PCP and other providers.

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

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

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

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

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

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

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

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

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

Collaboration/Compact Agreement Resources

Sample care compact agreements for various specialties, including:

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

9. Primary Care/Orthopedics Service Agreement (2-page PDF) – Example of a service agreement between primary care and orthopedics
10. Service Agreement Between Specialty and Primary Care Medicine (3-page PDF) – Example of a service agreement between specialty services and primary care
11. Gastroenterology Service Agreement (2-page PDF) – Example of a service agreement between primary care and gastroenterology

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

Webinars

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

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

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

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

Resources for Milestone 7: Shared Decision Making

Tools and Resources

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

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

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

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

Webinars

Improve Patient Shared Decision Making Capacity, Oregon Learning Session, Jan. 17, 2013 (25-page PDF)
Covers the fundamentals of SDM: definition, why it is a hot topic, lists conditions where it is likely to be of use, points to where to find tools and resources, describes models for implementation and discusses costs for implementation.

Integrating Shared Decision Making into Primary Care Practice, Part 2, Oregon Learning Session, Sept. 5, 2013
Content focuses on these objectives: Criteria for achieving CPC Milestone 7, review of SDM principles and decision aids, implementation strategies, workflow importance, examples of workflow, status report from a sample of Oregon CPC practices. Slides, transcript and video posted.

Overview of Shared Decision Making, National CPC presentation, July 25, 2013
This presentation provides an overview of Shared Decision Making (SDM), defines Decision Aids and describes models of implementing SDM. Slides, video and transcript from the presentation are posted.

An Overview of Shared Decision Making, Oregon Learning Session, Oct. 29, 2013
This presentation provides an overview of Shared Decision Making, explains the purpose of the SDM Milestone and reviews some foundational principles.

Overview of Shared Decision Making, Virtual Site Visit, July 31, 2013 (17-page PDF)
National CPC presentation provides an overview of Shared Decision Making, including participation from two practices that share their approaches to selecting and implementing SDM tools.

Shared Decision Making, Ohio Learning Session, April 10, 2013 (40-page PDF)
This webinar defines decision aids, highlights barriers and describes the steps toward Shared Decision Making.

Shared Decision Making and Decision Aids, New York Learning Session, March 21, 2013
Presentation provides a common understanding of Shared Decision Making and describes how to initiate informed decisions in the primary care practice.

Shared Decision Making Skills for Providers, Colorado Learning Session, Oct. 30, 2013 (43-page PDF)
Presentation from the Informed Medical Decisions Foundation featuring CMO Richard Wexler, MD, and Julie Riley, MS, Learning Specialist.

Health Disparities Series: Equity and Shared Decision Making, National Webinar, Feb. 13, 2014 (40-page PDF, transcript and video)
This presentation focuses on linking equity and Shared Decision Making, equity issues to consider when implementing Shared Decision Making and stories from the field.

Shared Decision Making Part 3, Colorado Regional Webinar, Dec. 5, 2014 (42-page PDF, transcript and video)
This presentation focuses on measuring and tracking DA distribution to meet CPC requirement and modifying workflows to accommodate DA distribution and measurement.

Shared Decision Making, Arkansas Regional Webinar, Dec. 12, 2013 (18-page transcript and 51 min video)
This regional presentation focuses on preparing for PY 2013 web app submission for Milestone 7: Shared Decision Making.

Resources for Milestone 8: Participation in the CPC Learning Collaborative

No resources at this time

Resources for Milestone 9: Health Information Technology

Tools and Resources

Attestation User Guide for Medicare Eligible Professionals (75-page PDF)
Attestation User Guide for Medicare Eligible Professionals, provides step-by-step guidance for EPs participating in the Medicare EHR Incentive Program on navigating the Meaningful Use attestation system.

Attestation Worksheet (8-page PDF)
Attestation Worksheet for Eligible Professionals: allows eligible professionals to document their attestation data on paper, before they attest in the Meaningful Use attestation system.

CMS' PQRS Information
Overview of PQRS, a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs).

HRSA Resources
This site describes Meaningful Use, the Stage 1 CQMs, how they are calculated, reported and attested and additional Meaningful Use Clinical Quality Measures resources and information.

Meaningful Use Attestation Calculator
This tool allows EPs and eligible hospitals to determine if they have met the Stage 1 Meaningful Use guidelines before they attest in the system.

Registration & Attestation Page
This site includes information on registration and attestation to Meaningful Use, and links to additional resources.

Meaningful Use Resources on the Collaboration Site
CMS has several resources located on the EHR Incentive Programs website to help EPs properly meet Meaningful Use and attest. The consolidated information helps eligible hospitals and professionals reduce the time and resources needed to implement validated and endorsed health quality measures. Select to access additional information. Data are made publicly available in USHIK by a federal partnership of AHRQ, CMS, NIH/National Library of Medicine and the Office of the National Coordinator for Health Information Technology.

Regulations and Guidance/Legislation for EHR Incentive Programs Section
This site provides information about the Medicare and Medicaid EHR Incentive Programs. These programs provide incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate Meaningful Use of certified EHR technology.