The CPC Pathway — Program Year 2013

Introduction

The CPC Pathway — Program Year 2013 is the Comprehensive Primary Care (CPC) Initiative's presentation of CPC practice approaches to the work of the initiative's first year. This information is intended to meet the needs of practices that are early in the CPC Milestone work as well as those testing additional strategies to improve and refine their ability to provide comprehensive primary care.

This Guide maps the pathway for the practice capabilities needed to provide comprehensive primary care through nine corridors of work known as the CPC Milestones. The first year's Milestones outline the basic work streams; they are not stand-alone initiatives. The work in the Milestones builds the delivery system capable of providing the five comprehensive primary care functions:

- Access and Continuity
- Planned Care for Chronic Conditions and Preventive Care
- Risk Stratified Care Management
- Patient and Caregiver Engagement
- Coordination of Care

These primary care functions, supported by enhanced accountable payment, continuous improvement driven by data, and optimal use of health information technology, in a multi-payer environment, will result in improved care and health outcomes, and reduce the overall cost of care.

The practices in CPC are heterogeneous in size, geography, ownership and organization. The design of the CPC model is specific about the services to be delivered (the five primary care functions) yet flexible in how the primary care practices deliver these services. The CPC Milestones outline corridors of work that build capability to provide these services, recognizing and expecting that practices will innovate and adapt practice changes to their own context and circumstances and the needs of their patients.

Each section of this guide opens with the intent of the Milestone and the outline of practice changes envisioned in the work in that Milestone as well as a link to the relative change concept in the CPC Change Package. This is followed by a description of how the work may take shape according to a practice's specific context and the needs of the patients they serve. At the heart of each section, CPC practices share the specific changes they have made in their practice and the structures and process they have implemented.

The **Tools and Resources** section lists publications and tools for a deeper understanding of the particular Milestone as well as presentations from CPC subject matter experts and peer practices. Completing each section are **Frequently Asked Questions** that CMS answered over the course of the year. These questions offer insight into practices' day-to-day concerns as they planned, tested and implemented new processes.

A digest of resources are located in the Appendix and includes the following:

- The CPC Change Package, which delineates the tactics and concepts that support the drivers leading to Comprehensive Primary Care
- A compilation of all resources listed throughout the Milestone sections in this Guide
- Spotlight articles that provide an in-depth look at individual practices' work in the CPC initiative

This guide captures the energy, innovative ideas, rigorous and determined work of the CPC practices as they tested and implemented these changes in their practice. Through this Guide we hope you find in your colleagues' work valuable support for transformation toward comprehensive primary care.

May 2, 2014

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Milestone Overview

The synopsis below provides a brief, high-level description of each Milestone. The details of Milestone intent, work elements and approaches can be found in the individual Milestone sections in this Guide.

Milestone 1: Budget Forecast

Milestone 1 is intended to help practices prioritize, plan and budget for the activities and resources required to deliver comprehensive primary care capable of improving care and health outcomes and reducing the overall cost of care, through work in the CPC Milestones.

Milestone 2: Care Management for High-Risk Patients

Milestone 2 addresses the health of the practice's entire patient population with a specific focus on risk stratification and care management for those at highest risk for poor health outcomes and avoidable harm.

Milestone 3: 24/7 Access by Patients

Milestone 3 increases access to care while supporting the relationships that lead to improved health outcomes.

Milestone 4: Improve Patient Experience

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 the patient perspective and engage patients and families as partners in improving care.

Milestone 5: Use Data to Guide Improvement

Milestone 5 guides a systematic approach to using practice data to improve care.

Milestone 6: Care Coordination

Milestone 6 work addresses systematic coordination of care across the medical neighborhood.

Milestone 7: Shared Decision Making

Milestone 7 focuses attention on ensuring that patients and families receive the information they need to be engaged, informed and effective partners in their own health care.

Milestone 8: Participation in the CPC Learning Collaborative

Milestone 8 involves active participation in a learning community to build the knowledge, skills, competence and practice capacity to deliver Comprehensive Primary Care.

Milestone 9: Meaningful Use

Milestone 9 leverages the Meaningful Use program as a foundation for optimal use of the electronic health record in the care of patients.

Milestone 1: Budget Forecast

Intent of Milestone 1

Milestone 1 is intended to help practices prioritize, plan and budget the activities and resources required to deliver comprehensive primary care capable of improving care and health outcomes and reducing the overall cost of care, through work in the CPC Milestones.

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.

Work Elements for Milestone 1

1. Estimate revenue from the enhanced, accountable payment in CPC, based on the first quarter funding.
2. Map out the practice changes that will be required by the CPC work in the PY 2013 Milestones.
3. Estimate the cost of CPC changes.
4. Prioritize changes and allocate projected revenue toward those changes.
5. In most cases, the cost of potential changes may exceed projected revenue and the practice should consider whether to invest additional resources in the changes.

The changes that are prioritized for investment should be those that help accomplish the work of the Milestones and build practice capability and capacity to provide better care and improve health outcomes, while reducing the overall cost of care through improvement.

Documenting the Work in Milestone 1

Within three months of enrollment in the program, practices submitted an annual budget that included anticipated CPC revenue from all payers and projected investments in practice changes associated with CPC. Practices organized their budgets according to specific expense categories either using a template provided by the CPC program or customized templates including the same specific spending categories.

Practices' Approach to Milestone 1

Developing the CPC Budget

St. John Clinic, Sapulpa, Oklahoma (14-practice system)

The first step in St. John Clinic's budget process was to access the CPC collaboration site to download the budget spreadsheet template, which identifies the major categories of work within and across the Milestones. This also helped us narrow our focus to those categories of work and clearly define our budgeting priorities.

Then we obtained revenue projections from participating payers, including CMS, to forecast the funds that would be received in 2013. Since the budget was created at the beginning of Program Year 2013, some funds were forecasted as received for the last three months of 2012.

After updating the budget spreadsheet to record funds actually received for 2012, we submitted it in the CPC web application. The final budget noted where the actual funds differed from the forecasted amount.

The next step was to forecast the budget costs for each Milestone. Our staff reviewed each Milestone, the anticipated work and the staff role that would be assigned to that work. We assessed that a central care manager would be needed particularly for Milestone 2 but also for Milestones 3, 5, 6 and 8. Along with salary, St. John staff identified the costs for benefits and training for the care manager who would train and cover all of the care managers in the system. This position would also interact with payer case managers, work with care managers and physicians to analyze utilization data, and attend all learning collaborative meetings.

Our practice sites identified coaches to meet the objectives Milestones 2, 4, 5 and 8. The rationale was that as a health system, we would add the positions and spread the work across several sites so processes would align across the system, but practice personnel could develop site-specific processes.

Following the Dartmouth Coaching methodology, we hired registered nurses to help meet the objectives of Milestones 2, 3 and 7. Traditionally we only staffed with medical assistants. For budget year 2013, our practice forecasted the cost of staffing with a few nurses and lowered the medical assistant ratio to test if conversations with patients could be raised to a higher level of quality.

Health Information Technology costs included the cost of connecting to the community's HIE, which would facilitate health information sharing to support Milestones 2, 5 and 6.

An important category of cost was team meetings. We set aside two hours a week for the entire clinic to work on process improvement. We have also incorporated health maintenance and disease registry goals into the physician compensation plans. Our practice leadership felt that paying the physicians for work not directly associated with a patient visit would effectively introduce value into the physician compensation plans. For the CPC initiative, working within multi-disciplinary teams was essential for creating new and effective processes and protocol development. We forecasted for meetings to collaborate across the CPC and not lose compensation.

The actual costs of the items forecasted in the budget will be updated in first quarter of Program Year 2014.

Developing the CPC Budget

Stillwater Family Care (Office of Dr. Garrick L. Shreck), Stillwater, Oklahoma (independent practice, one physician)

Note: Dr. Shreck's office shares infrastructure and some staff expenses with four physician practices that comprise Stillwater Family Care.

Constructing the budget started with a template similar to the recommended excel spreadsheet on the Collaboration Site.

The budget was directed at increasing our practice's capability to achieve all the Milestone objectives. As each Milestone was reviewed, we determined what work would be necessary to successfully meet its objectives, and at the same time, identified how this capability would help other Milestones. Our budget forecast covered the resources and the tools for the capabilities required. Where there was a gap in the practice's capability to achieve the Milestone, we assessed what functionality, capability or resource would fill the gap. If needed, that item was added to the budget. For example, the cost of a care manager (the number of hours that person would work) was added to support Milestone 2 activities, while recognizing this cost would help meet all Milestones' objectives for Program Year 2013.

Building HIT Capability. Using HIT to its fullest capability would require staff training and IT leadership support. We estimated training hours needed and costs associated with that training. We had already attested to Meaningful Use in 2011. However, we saw a need for ongoing IT support for CPC work, which included developing forms for patient care in EHR and software to interface with the Oklahoma's immunization registry and the regional HIE. This helped to meet objectives for Milestones 2, 5 and 6.

Milestone 2 activities were further supported by risk management software obtained for the RN and physicians to use in stratifying patients. We did not budget additional costs for Quality Metric reporting as our EHR had that capability. The cost to host the patient portal functionality was identified and added, which helped achieve Milestone 3 and 4. It was also necessary to add the cost for the temporary IT personnel to enhance the website with the Patient Portal. Part of the Patient Portal costs included the functionality that integrated registration and patient history forms with the EHR. Other IT costs included the cost of laptop for a care manager and an iPad for supporting the nurse in care planning while with the patient in the exam room. The Televox software was added for sending automated reminder calls to patients about appointments. This functionality was targeted to help the practice support the objectives for Milestone 2, 4 and 5.

Workflow Development. To identify the budget items required to support the workflow, we evaluated the current workflows associated with achieving the Milestones, their activities, the resources to support those activities, and the staff who would complete those activities. We assessed the staff time and reflected that in the budget. Knowing that developing efficient workflows would leverage the investment in HIT, we estimated provider and staff time that would be necessary for developing and making changes toward continuous improvement in risk stratification, protocol development for planned visits and other processes. Workflow was assessed for the new positions of a care manager and a case manager. For example, the care manager's role concentrated in non-visit patient interactions, and staff time allotted for these interactions were estimated.

The budget showed that the work of CPC involved participation in the CPC face-to-face and virtual meetings as well as internal team meetings, scheduled both during lunch and after business hours. Our practice noted that these meetings would also be used as a means for training staff for the work involved with CPC. As the work was assessed for each Milestone, it was noted that to meet Milestone 3, the office hours would remain the same as the physician would use the open access schedule they used previously, which allows patients to access the on-call providers 24/7 through the paging system. The workflow for Milestone 4 involved organizing quarterly Patient Advisory Board meetings, and staff time for that workflow activity was accounted for in the budget. The cost of communicating with patients was included, e.g., the cost of letterhead, postage and envelopes used to notify patients about CPC activities.

Additional Resources. The practice evaluated how to make the entire system of care enabling the CPC Milestone achievements more efficient. As a result, funds for a new phone system were included to support the care team approach. The cost of informational handouts about the patient portal was also added.

Tools and Resources for Milestone 1

Click here to access the complete list of resources for all Milestones.

The program provided a budget template and written guidance to support the budget process. Additionally, national and regional learning webinar presentations and live events provided topic-specific discussion and guidance from CPC faculty.

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.

Tools

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.

FAQs for Milestone 1

Below are questions practices asked during PY 2013 as they were completing the day-to-day work of CPC. These frequently asked questions are provided here to illustrate various practice approaches to achieving the Milestones and specifics that needed to be addressed as practices implemented innovative tactics.

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1.1 Developing a Budget

Q: How should our practice develop the budget?

A: In considering Milestone 1 (PY 2013 budget), CMS is looking for your practice to plan your spending, answering the following questions:

- What investments will we make to increase our ability to achieve the PY 2013 Milestones and deliver the five Comprehensive Primary Care functions?
- Will these investments lead to a reduction in the total cost of care through improved care and improved health outcomes?
- Given that the resources are finite, is this portfolio of investments the best way we can address questions one and two?

The budget is both a planning tool for you and a way for CMS and other payers to understand how you will be using the enhanced payment to build capacity to meet the CPC Milestones and deliver comprehensive primary care.

1.2 Guidance about appropriate expenditure of CPC revenue

Q: Do we have to spend all the expected expenditures within the calendar year?

A: Your practice should plan to spend all of the enhanced payment on making changes to your practice to meet the CPC Milestones. You should generally not hold back funds, although you may elect to hold back a small cushion in case revenue does not match projections. You will not be held to the specific spending decisions within your budget, but will be asked in early 2014 for an account of how you actually spent your CPC revenue.

Q: The quality bonus that our insurance contract was paying prior to signing the CPC contract went away. Can we use CPC funds to replenish these missing funds?

A: CPC funding should be used to meet the CPC Milestones. You should analyze whether your portfolio of CPC investments will likely lead to a reduction in the total cost of care through improved care and improved health outcomes. Depending on the quality improvement work you were doing prior to CPC, the work may overlap with the specific quality improvement pathways in CPC Milestones 5 and 6, and you could include it in your CPC budget. Quality Improvement work may include work for other programs such as NCQA PCMH Recognition, Meaningful Use Incentive Program, among others.

Q: Can we use the CPC revenue to "back-fund" practice transformation work we did before CPC at a loss, or to support line items that already existed?

A: No. All expenditures should be for new capacity, not to recover expenses incurred in practice transformation in the past. CPC dollars should not be used to supplant current investments.

Q: Can we "bill" the taxes we will pay on our CPC revenue back to our CPC budget?

A: No. Taxes are not a permissible expense.

Q: May CPC funds be used for registry software support?

A: Yes, this is an appropriate expense, if it is a new investment that supports achievement of the yearly Milestones and CPC functions. If it is an expense previously funded by other revenue streams, CPC dollars should not be used to supplant those streams.

Q: Can we increase physician salaries?

A: The receipt of non-visit–based revenue through CPC is an opportunity to align provider compensation with the provision of comprehensive primary care. There will be new work from clinicians that is not directly revenue generating and important patient care delivered by members of the care team working to the highest level of their licensure. New work could lead to changes in salary with productivity being measured and rewarded differently, although CMS does not expect this to constitute the bulk of your revenue investment.

Q: Can we direct funding toward existing staff with new CPC duties assigned? (For example, could CPC funding be used for an existing LPN who will now be a care manager or an existing practice manager who will now work 50% on CPC?)

A: CPC funding should be used to increase practice capacity. The answer to the example above really hinges on whether the change represents one, an overall increase in staff (adding care management to existing staffing levels); or two, is simply a re-labeling of duties. In the first case (adding), then this is an acceptable use of CPC funds. In the second case (re-labeling), this would indicate the use of CPC revenue to cover existing costs ("supplanting"), which is not acceptable. Appropriate use of CPC funds on existing staff could include providing new training or "buying up" all or part of an FTE. With increased training, a promotion might be justified, and CPC funds could be used to support the difference in pay (not the total salary).

Q: If a billing company takes a percentage of our CPC payments, how is this accounted for in the budget? For example, one practice has noted that its billing company is going to take 5.5% of CPC payments.

A: This is not considered a permissible expense for CPC payments, as it does not support practice transformation or the Milestones.

Q: In a system with multiple practice sites, can money for the CPC practice(s) support resources for other non-CPC practices in that same system?

A: CPC funds are to be dedicated to CPC practices completing the yearly Milestones and achieving the CPC functions over the four years of the initiative. They should not be used for non-CPC practices.

Q: Our practice has a Saturday clinic, but due to high costs and low revenue we have considered eliminating this offering. Could we use the CPC money to keep this open and available for patients?

A: The expansion of hours is an appropriate expense; however, it is not a requirement of PY 2013 Milestones. You should take a comprehensive look at PY 2013 Milestones and ask what it will take to accomplish them. Expanding your hours could be part of a broader strategy.

Q: Is the cost of staff/personnel time spent in attending Learning Sessions a permissible expense?

A: Attendance at the Learning Sessions is just one example of many activities that are not specifically visit-related and therefore not revenue-generating in a fee-for-services (FFS) environment. It is fair to value the cost of a meeting as the amount of revenue foregone by the providers who attend the meeting.

Q: Could we hire or contract for additional certified coders?

A: Coding is a basic practice function and is not likely to be a good investment in achieving the CPC aims. The risk stratification process in Milestone 2 is a clinical process that will draw on available information sources to identify those patients most likely to benefit from intensive care management services. A variety of potential information sources is available, including diagnoses. A critical early step in Milestone 1 is to identify the algorithm or approach you will use to risk stratify and then to identify whether this approach or algorithm will require an investment in new data sources. Certainly, improving the entry of structured clinical data (including labs, reports, discharge summaries, outside tests and immunizations) is an important change that many practices will need to make, but this is not coding.

Q: Do ongoing maintenance costs for existing IT infrastructure (like portals and software) qualify for CPC funds if patient care is improved?

A: Maintenance of an existing HIT system is a basic practice expense and not an expense that directly links to accomplishing the Milestones or achieving the CPC aim. System enhancements that clearly link accomplishing the Milestones or reducing the total cost of care through improved care are appropriate expenses.

Q: Would the cost of digital radiography be considered an acceptable purchase using CPC funds?

A: No. The evidence is quite clear that in most cases additional testing capacity leads to additional tests and additional costs and not necessarily improved care. You should be prepared to show clearly how an investment leads to reduced cost through improvement in care, a highly unlikely result from the purchase of imaging equipment.

Q: Would an EHR provider contract for CAHPS expertise and survey tool be an appropriate use of CPC funds?

A: Yes, using CPC funds for a validated survey tool through your EHR on an ongoing basis would be an appropriate use of funds. Before investing a lot of money into this survey tool, consider whether PY 2014 Milestones contain any changes that would influence your decision on this investment.

1.3 How to fill out the budget tool

Q: How much detail is required for each line of the budget?

A: The budget should give enough detail to provide a picture of how you will achieve the Milestones. The details can be abbreviated, but anticipated actions should be clear (for example, hiring a Care Manager). Even in instances where no dollars are spent, notes about existing resources in a practice being leveraged for achieving

CPC Milestones should be included to prevent the appearance of gaps in the budget. Explanations in the "notes" should be concise but clear.

Q: What if we know our anticipated expenses for CPC, but expect that our CPC additional revenue won't cover them fully – rather, our hospital system would absorb the additional costs? Should we document all of our anticipated expenses even if they exceed projected revenues?

A: Yes, please include all expected new investments toward the CPC aims. This is good, valuable information for evaluating the practice costs of providing comprehensive primary care services. You are not being judged on whether you spent within your budget at year's end.

Q: We receive PMPM payments from one of our payers under two different product lines. How should we indicate this in the CPC Web Application?

A: Combine the payments from this payer into a single field for that payer in the Web Application.

1.4 Amendments/corrections

Q: If we decide to change budget line items (for instance, adding a PharmD into the practice, taking away money from another line to add it), do we need permission to delete or add to different areas of the budget as the year progresses?

A: No. Permission to make changes, delete or add items to the budget is not needed. You may use the Web Application to track your actual spending throughout the year, but are not required to do so.

1.5 Budget review by CMS

Q: What is the process for review of budget submissions?

A: CMS will not formally approve budgets or expenditures as one might see in a grant program. You will receive feedback from Faculty about one, appropriateness of expenditure decisions, and two, clarity. CMS will ask you to account for how you actually spent the PY 2013 CPC funds at the start of PY 2014 and may provide feedback during the course of PY 2013 if your budget raises concerns.

Q: How will expenditures be evaluated at the end of PY 2013 and at the end of the initiative?

A: CMS will evaluate practices based on completion of the Milestones, which are conditions of participation in CPC. The budget process is meant to assist practices in identifying and funding practice changes that will facilitate the completion of the Milestones and move practices toward the CPC aim of reduced total cost of care, improved care, and improved outcomes. At the end of the first year, CMS will ask practices to report how the money in the first year was actually spent and to provide a new budget for the second year.

Milestone 2: Care Management for High-Risk Patients

Intent of Milestone 2

Milestone 2 addresses population health with a specific focus on risk stratification and care management for those at highest risk for poor health outcomes and avoidable harm.

How Milestone 2 addresses the CPC Change Package

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.

Work Elements for Milestone 2

1. Commit to a population view by empanelling all active patients: assign each patient currently receiving care in the practice to a practitioner and/or care team who has primary responsibility for the care and outcomes for that patient.
2. Identify an explicit methodology that incorporates multiple sources of data to risk stratify or segment the population. Sources of data might include the following:
    - Clinical data and diagnoses from the EHR
    - Payer claims data
    - Hospital and ED discharges
    - Health risk assessments or other patient assessment processes
    - Clinical judgment
3. Apply that methodology to stratify every empanelled patient to a risk cohort and document this in the EHR. This process of assigning risk cohorts should be dynamic, adapting to changes in health and risk status. Some practices use an algorithm to assign a risk status to all patients at once and modify that assignment over time. Other practices assign risk status to patients as they receive care in the practice.
4. Develop care management capability and capacity with staff time dedicated to this role and a commitment to use these services to improve care and outcomes for those patients identified as at highest risk. Most practices use an RN care manager in this role; some practices divide the role among multiple staff. For most practices, effective care management requires training and hiring of additional staff.
5. Develop clinical workflows and policies to support care management of patients at highest risk as a core function of the practice and care team.
6. Implement an approach to planning and documenting plans of care for those at highest risk. This is a critical but quite challenging step since current EHRs lack support for efficient patient-centered care planning and documentation.
7. Continually refine the risk stratification methodology and enhance care management capability to achieve the best match between the needs of those patients identified as at highest risk and the practice ability to meet those needs.

Documenting the Work in Milestone 2

CPC practices provided information on their process for population management, risk stratification and care management of high-risk patients to include the following:

- rates of empanelment
- risk stratification methodology
- number and percent of patients in each risk stratum and those in each risk stratum who received care management
- care management capacity; identifying the capacity added as a result of participation in the CPC program
- description of the role of the practice care manager (in many cases this was a position description or policy)
- description of care management clinical work flows
- care plan examples that exemplify the practice's approach to care management

Practices' Approach to Milestone 2

Risk Stratification Methodology and Care Management Staffing and Training

St. John Clinic, Tulsa, Oklahoma (system)

Methodology. Using the AAFP tool as a primary resource and reference, our ambulatory medical director and central care manager defined the risk factor criteria for six levels of strata and developed a tool for the care managers' use.

In addition to the tool, care managers review the patient's chart, looking at the patient's major problem list, current list of medications, vital signs, past medical history, referral consult documentation, hospitalization history and progress notes from the PCP. The chart also includes consultation reports and care visits to other facilities. This data allows continual adjustment of care plans as changes occur to the patient's health needs. Once patients are assessed, a suitable, personalize care plan is developed.

Care Management Staffing. We determined how many care managers were needed by estimating 10 percent of each physician's panel would fall into the two highest risk categories. Initially, we had hired medical assistants to do the work, but then decided to hire RNs.

Job Description. Our job description describes the care manager as "managing patient care in the health care continuum to achieve optimum outcomes in a safe and cost-effective manner and developing relationships with patients as an integral member of the team." To support success in this role, experienced care managers train new managers on risk stratification methods. After training, care managers are fully prepared to assess patients for risk stratification.

The Central Care Manager and Training New Care Managers. The central care manager represents the practice at hospital admission meetings in the community, serves as an internal resource to the health system and attends CPC group meetings outside the health system. She meets monthly with RN care managers and the practice managers, checking in on how they are doing the work aligned to care management. We expect the central care manager role will continue to expand over time.

The practice created a central care manager’s office in an empty suite. As other care managers are hired, they initially share this space with the central care manager as they train on risk stratification. This group training environment created an unforeseen benefit: after care managers “deployed” to a practice site, they developed camaraderie with their care manager peers and would look to the central care manager for guidance, despite technically reporting to the practice manager in their home clinic.

The care manager’s responsibilities include patient care related to transitioning patients between care facilities at this practice. Between 8 and 9 a.m., the care manager checks on the inpatient status of patients when that information is not available in the HIT system. She calls local hospitals and searches in the EHR application for St. John inpatients. Patients who have been discharged must be contacted within two days for follow-up care; this is a high priority task. Then she risk stratifies patients who were seen the previous day for follow-up from a hospitalization.

If a patient has been referred to another provider, the care manager will fax patient information to that office before the appointment is set. This information allows the provider to determine the nature of the appointment and schedule appropriately.

These tasks are carried out early in the day, when patients generally prefer not to be called. Using the early part of the day to do investigative work keeps the care manager informed, and leaving the calls to later in the day improves patient satisfaction. Currently the care managers are focusing on hospital transitions, home health certification and pre-visit phone calls (in between visit care). Working together as a team, our staff has an effective workflow to notify the care manager when a patient’s change in health status prompts a change in the risk stratification and the subsequent post-discharge follow-up phone calls.

The influence of care management is clear in the positive feedback we receive from patients. The care manager has made a big difference in the workflow and its effect on customer service and teamwork. A big part of her work is to provide follow-up contact with patients, when indicated, to ensure compliance with recommendations — medications, lab/x-ray, specialist visits, PCP visits and dietitians. The patients enjoy the phone calls from the care managers, especially the education and support. The care manager answers difficult questions from high-risk patients, so those calls do not always have to be forwarded to the physicians, avoiding a delay in their schedule. We think more care managers and fewer MAs are needed in the clinic, so we are actively working on a proposal to hire more care managers.

Care managers from all sites also meet regularly for educational purposes (for example, meeting to hear from the home health and hospice department).

New EHR. Since our practice is in the process of adopting a new EHR and EHRs do not generally accommodate care management workflows automatically, the current “work around” workflow will change drastically. Our expectation is it may be several months post-adoption to smooth out the new care management processes.

Barriers. The amount of hospital transitions and pre-visits on any given day varies. Receiving discharge summaries from other facilities outside of St. Johns and St. John Tulsa are the barriers we face. Information on some transitions, depending on the patient and severity of the hospital stay, can take up to 45 minutes each on the phone to give and receive. Sometimes the practice does not receive discharge summaries on St. John Tulsa patients, and although the care manager does not let this interrupt her flow, it remains a barrier. This is a continual work in progress and some weeks are better than others.

In the beginning, care management methodology was difficult to assimilate and operationalize for the providers and staff. The positive surprises are how much of an asset it is to have a care manager, how easy the workflow was to get started and seeing the positive outcomes so quickly.

Care Management Methodology, Staffing, Responsibilities

Summit Family Physicians, Middletown, Ohio (group practice, three physicians and one NP)

At Summit Family Physicians (SFP), the approach to Care Management started with the budgeting process. We needed to ensure we accounted for costs associated with the people, processes and infrastructure necessary to build our capacity and capabilities to risk stratify patients and manage their care well. We accounted for the following in the budget:

- Physical changes in office to accommodate Care Management services
- Phone system upgrade to accommodate additional staff
- Staff time for training and workflow development, time to develop and implement risk stratification criteria and input to chart
- Additional providers hours to develop and implement risk stratification capabilities and input into the e-chart
- 1 FTE RN care coordinator
- 3 FTE LPN/MA

Our risk stratification model. After reviewing different risk stratifications methods, we decided to use a modified version of the AAFP risk stratification model, which we initially simplified to three levels by merging levels. AAFP levels 1 and 2 became our low risk stratum (Level 1), levels 2 and 3 are medium (Level 2) and levels 4 and 5 are high risk (Level 3). The simpler three-level model allows all staff to be able to easily stratify patients and provide the appropriate care management to those at the highest risk level.

As we risk stratified patients for the entire practice, we identified a group of high-risk patients who need care management at least monthly. For those patients, we created a second, higher stratum in the high-risk group, which is Level 3A.

Risk stratification occurs at pre-visit planning or at the time of visit by staff trained to risk-stratify the patients. Our criteria include number of chronic diagnosis, number of medications, number of high-risk medications, number of ED visits and hospital readmissions, expected death in 12 months, and claims payment. The patient's stratification level is easily identified on the EHR face sheet, and reports can be generated for each risk level. All patients are empanelled to a provider to ensure continuity of care.

Care plans for the risk-stratified patients link the patient's goals and action plans to the patient's risk factor, along with expected outcomes and periodic evaluations.

We also created a plan to track attributed patients versus non-attributed patients (attributed patients are those for which the practice receives PMPM payments for their care). This is simply an administrative function and does not influence how health care services are provided.

How we support care management. People, processes and technology facilitate care management. The care management staff are three physicians, one nurse practitioner, two registered nurses, two LPNs (1.5 FTE), five medical assistants and 12 clerical staff (3 FTE).

Processes: the job description. The patients and staff are supported with processes developed to provide efficient and consistent care. The first process was to develop a job description for care coordinator that allowed the practice to attract the right person with the right skills. The job description lists required skills and license, but also emphasizes attitudes for success. The description also highlights the work of patient care, patient education, patient assessments and coordination of services across multiple settings of care.

We created a responsibility chart that linked each position with its responsibilities to access and manage the patient population, to support and coordinate care as well as to improve the quality of care for patients at all risk levels.

Supporting the responsibility chart are workflows. These range from a follow-up phone conversation with a patient after a visit, to a workflow for ED utilization/hospital admission, which tracks these patients and then assigns education and care coordination activities appropriate for that patient. This workflow also addresses follow up with patients after hospital discharge and assists in preventing readmissions. A care coordination workflow for Level 3A /Plan 3A patients (our highest risk patients) aims to provide high quality, seamless care coordination across different providers and transitions of care and to reduce fragmented care, decrease hospital readmission and improve patient outcomes.

Technology. From March to November 2013, we used a workaround template in Allscripts (the EMR). In November 2013 we obtained built-in care plan documentation in Allscripts.

The Effect of Care Management on the Practice. Care management has been integrated throughout the office, starting in October 2012, when the practice created workflows and defined responsibilities for each job description. Each person was trained with core educational materials, regardless of his or her job title. All staff members understand they can positively or negatively affect patient care, and all staff is comfortable sharing educational materials with patients.

The care coordinator’s responsibilities:

- High-risk patient population – making monthly phone calls to assess the status of the highest risk patients and follow up.
- Calling hospitalized patients within 48 hours of discharge; reconciling medications, and making the follow up appointment with the patient’s provider within one to two weeks of discharge.
- Pre-visit planning —Daily review of charts for care gaps and health maintenance opportunities with patients being seen that day.
- Establishing and facilitating six monthly classes for patients with diabetes and forming future classes (CHF, COPD).

Medical assistant hours have increased with added, daily care coordination responsibilities. A previously part-time registered nurse is now full-time as she works on ER utilization. Phone staff has expanded responsibilities with scheduling for access, calling patients who are not making timely visits, and managing the referral process and follow up.

Recognizing physicians and CNPs are central to care coordination, the MDs and CNP set aside time to meet with care coordinators and medicals assistants every day.

Sharing Information Across the Medical Neighborhood. We share information across the medical neighborhood more effectively through a formal referral process. The referral specialist will schedule a referral and send supporting documentation from the EMR to the specialist's office. Within 30 days, the referral specialist will follow up to make sure the referral was completed, and the specialist consult is put in the EMR. The practice maintains excellent communication with the hospital and referring labs using the Health Bridge Health Information Exchange and the lab interface with Lab Corp.

Challenges. The greatest challenge has been to define realistic and beneficial parameters for care management staff. Everyone from patients to office staff has a different perception of what these positions should do. The opportunities were endless, while time is finite.

Problems were overcome by defining the care coordinator role and educating others about what to expect. In addition, the practice began building the care management team to fit the needs of the office, such as having a RN care manager on site.

As we implemented care management, we were surprised at how the process continually evolves over time and is not clear-cut or black and white. We have identified several patient needs in the care management process and the opportunities are endless. The practice's goal is to partner with the patients and assist them in meeting their health care needs and goals, but our challenge has been in engaging the patient in the process.

Trying to solve all the patient's problems in one encounter with patients proved to be a failure. We learned that care management works best over time by setting goals with patients and bringing them into the office more frequently.

It takes the team approach to be successful with care management. We initially thought that a care coordinator could pick up the extra workload and be available for other office duties. A better understanding of the work involved in care management changed this view.

Tools and Resources for Milestone 2

Click here to access the complete list of resources for all Milestones.

The CPC program has developed a working definition for care management that distinguishes the patient-focused processes of care management from the system-focused processes of care coordination.

Care Management is a tailored primary care function provided to patients at highest risk for adverse outcomes (including iatrogenic harm) that are potentially preventable. Effective Care Management results from a complex exercise of clinical judgment. It happens as relationship-based engagement with the care team that is proactive, longitudinal, and focused on meeting the patient's health and health care goals.

Essential features include:

- A mutually agreed upon and documented plan of care based on the patient's goals.
- Planned and documented pathways of care based on best available evidence and guidelines for care in the unique context of the individual patient.
- Proactive delivery – not waiting for visits or acute decomposition – and not primarily visit-based. Patient visits are opportunities to define goals, plan care, engage in shared decision-making, and build a trusting relationship, but most care management activities take place by phone, email, or home visits (as well as visits to SNFs or hospitals to support transitional care). These activities are appropriately targeted based on patient needs.
- Dedicated clinically trained staff working closely with the physician in a team-based approach to care for individuals with complex health needs. Staff is typically from the nursing or social work disciplines, but occasionally from other disciplines such as pharmacy.
- Activities which are documented in a structured way as part of the medical record, capturing critical information. These include the nature and substance of the contact, assessment of current status, changes to care pathway or overall care plan, unresolved questions, and next scheduled follow up contact.

Care Management is distinct from Care Coordination, which in CPC refers to the organization of care both within the practice and between the practice and community settings, labs, specialists and hospitals. Care Coordination activities include closing care gaps, coordinating care between transitions, and reducing fragmentation.

Care Management activities are person-focused, ensuring individuals at high risk get the care they need, and Care Coordination activities are system-focused, ensuring that care is seamless across providers and transitions.

NOTE: *While it is useful for planning and program development purposes to clearly distinguish between the **person-focused functions of care management** and **system-focused functions of care coordination**, the same individuals in the practice often perform both functions. Care management may, in fact include coordinating care for an individual who is in transition (e.g., between hospital and home). You will see in the Practice Approach stories that practices sometimes refer to staff members who are providing Care Management services as Care Managers and sometimes as Care Coordinators. These are new and evolving roles and functions and we expect that the language we use will evolve as well over time.*

Care Management Tools

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.

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

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.

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.

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.

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
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.

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.

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 their 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, ARK/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.

FAQs for Milestone 2

Below are questions practices asked during PY 2013 as they were completing the day-to-day work of CPC. These frequently asked questions are provided here to illustrate various practice approaches to achieving the Milestones and specifics that needed to be addressed as practices implemented innovative tactics.

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

Q: Are practices allowed to document the patient's risk level within the Practice Management EHR module, or should the risk level only be documented within the Clinical EHR Module?

A: Yes. The risk level can be documented in the practice management module. The key here is that the marker of the risk level should be visible and adjustable during the clinical visit.

2.1 Empanelment

Q: In Milestone 2, Section B of the Milestone Reporting Summary, the numerator asks for the total number of patients empaneled or identified in the EHR as being associated with a primary care practitioner or care team in the practice. Is it requesting the total number of empaneled patients associated with a primary care practitioner regardless of when the patient's last visit was, or only the total number of empaneled patients who are active (who have been seen in the last 12 months) and who are associated with a primary care practitioner?

A: Defining "empaneled" patients is up to you. Some practices are given definitions by the networks that own them or with which they are affiliated. Others create their empanelment definition appropriate to their context (e.g., practice contact within the last 12 or 24 months). It is possible for a patient to be empaneled even if you have not seen him or her in the last year. Defining patient empanelment is not a one-time process, so as time evolves, it may be beneficial to broaden the definition of active patients. Please refer to the CPC Empanelment Guide posted on the Collaboration website.

In general, once you begin to empanel all your patients and develop an active patient list, then you should risk stratify current patients and stratify new patients as they come into your practice. It is an ongoing process.

2.2 Patients in special settings

Q: Does CMS have instructions regarding patients who may be attributed to a practice but are being cared for by hospice or other groups? Those patients may be attributed to practices and are high-risk, but the practices typically wouldn't do the care coordination since other providers, such as hospice, handles these patients. Are practices expected to report these patients in their numerators and denominators on empanelment and care management?

A: These patients should still be included in your numerators and denominators. If a patient is in hospice and receiving services, then the care management load for the practice is minimal. But the patient should still be reflected on the high-risk list. You should actively manage the care, even if that means knowing that the patient is receiving comprehensive care through hospice and, therefore, won't need intensive care management from your practice.

2.3 Risk status methodology

Q: Are we required to assign a numeric score in the EHR or registry for risk stratification of a patient?

A: Milestone 2 does not require you to assign numeric risk scores, but it does ask that you use an agreed-upon and specific methodology to assign a risk status to every patient and that you track the number of patients in each risk stratum and the number of patients in each risk stratum who are receiving care management services. Risk stratification can and should be a dynamic process and should ultimately work toward a population-based approach – i.e., that those individuals who are at highest risk for avoidable harm are identified and that care management and coordination resources are applied to reduce that risk.

2.4 Risk stratification in large practices

Q: Our practice has about 13,000 patients, looking back over a three-year period. The process of risk stratifying all patients seems daunting, so we selected patients with diabetes and hypertension as our populations to risk stratify and care manage. Is this an OK approach for PY 2013?

A: Identifying a clinical methodology for risk stratifying patients, identifying the highest risk patients and applying care management resources to that high-risk cohort is the intent of the Milestone.

It appears practical and sensible to begin with active patients with certain diagnoses and to work back from there. However, it is likely that your utilization data (from CMS in the quarterly feedback report and beneficiary data, from reports received from other payers, and/or from hospitalization/ED data) reveals high-risk/high-utilizing patients that you will miss if you limit your approach to particular diagnoses. Eventually, you should aim to refine your clinical risk stratification algorithm to include, for example, patients with frequent hospitalizations or ED visits. In addition, the risk stratification methodology must assign some status to all patients. Over the course of the CPC initiative, CMS will likely ask practices to consider more systematic (less high intensity) care coordination activities for patients in lower risk cohorts.

2.5 Care management

Q: What is the definition of "care management" under the Milestone?

A: The CPC working definition of care management is available in PDF format on the Collaboration website: Care Management in CPC.

CPC practices have flexibility to define who provides care management services and how these critical services are integrated into the practices. These services have been clearly defined, as well as the requirement that they are provided by dedicated staff with dedicated time and whose role in providing these services is also very clearly defined. Provision of appropriate care management services for patients at high risk for fragmented care, avoidable hospitalization, failed transitions, medication adverse effects, and other harms is a core function of Comprehensive Primary Care and is a function the enhanced payment is intended to support.

Care Management is a tailored primary care function provided to patients at highest risk for adverse outcomes (including iatrogenic harm) that are potentially preventable. Effective care management results from a complex exercise of clinical judgment. It happens as relationship-based engagement with the care team that is proactive, longitudinal and focused on meeting the patient's health and health care goals.

Essential features include:

- A mutually agreed upon and documented plan of care based on the patient’s goals.
- Planned and documented pathways of care based on best available evidence and guidelines for care in the unique context of the individual patient.
- Proactive delivery – not waiting for visits or acute decomposition, and not primarily visit-based. Patient visits are opportunities to define goals, plan care, engage in shared decision making and build a trusting relationship; but most care management activities take place by phone, email or home visits as well as visits to SNFs or hospitals to support transitional care. These activities are appropriately targeted, based on patient needs.
- Dedicated, clinically trained staff working closely with the physician in a team-based approach to care for individuals with complex health needs. Staff members are typically in the nursing or social work disciplines, but occasionally from other disciplines such as pharmacy.
- Activities that are documented in a structured way as part of the medical record, capturing critical information. These include the nature and substance of the contact, assessment of current status, changes to care pathway or overall care plan, unresolved questions, and next scheduled follow-up contact.

Care Management is distinct from Care Coordination. Care Management is people-focused and refers to the organization of care both within the practice and between the practice and community settings, labs, specialists and hospitals. Care Coordination is system-focused and includes closing care gaps, coordinating care between transitions and reducing fragmentation. Care Management activities ensure that individuals at high risk get the care they need, whereas Care Coordination activities ensure that care is seamless across providers and transitions.

Q: We have decided not to hire a care manager but to divide the requirements of high-risk care management among existing staff. Is this an acceptable approach to the Milestone?

A: Provision of appropriate care management services for patients at high risk for fragmented care, avoidable hospitalization, failed transitions, medication adverse effects, and other harms is a core function of CPC and is a function the enhanced payment is intended to support. CPC practices have been given flexibility to define who provides care management services and how these critical services are integrated into the practice. However, these services must be clearly defined and provided by staff with dedicated time whose role in providing these services has also been clearly defined. One of the essential features of care management services is that there are dedicated and clinically trained staff members working closely with the physician or other provider in a team-based approach to care for individuals with complex health needs. Care managers typically come from in the disciplines of nursing or social work, but occasionally from other disciplines such as pharmacy.

Q: Our practice uses care managers supplied by and paid for by our payers. These care managers work in our practices providing management of high-risk patients by payer. We have also hired care managers paid for by CPC care management fees. Should we include the payer-supplied care managers in our reports for this Milestone?

A: Since we are asking your practice to care manage your total patient population, you should include all staff even if the funding source is not from the CPC. Your practice could be covering staff salaries with your general operating budget or another source such as payers or grants. Please use the care manager job description document to describe the different types of care managers and funding sources that may cover their salaries.

Q: Question 2D on the Milestone Reporting Summary contains a table for reporting our care management staff. How should I count the FTEs and "average patient caseload per practitioner"?

A:

- "Approximate FTE currently allocated to care management services" means, for each type of employee, how many TOTAL FTEs of that type you have at the practice. For example, if you have three NPs each working 0.25 of their time on care management, you would report 0.75.
- "Approximate FTE allocated to care management services prior to CPC start": similarly, please add up the full amount of FTE capacity you had at this site before the start of the initiative.
- "Average patient caseload per practitioner": please consider all the patients receiving care management (as defined by CMS) at your practice and indicate how many of them on average are seen by the care manager(s) of each type. Do not include the patients receiving care coordination in the form of follow-up communications with EDs/hospitals in this total. For example, if 100 patients at your practice receive care management, 50 from a MA and 50 divided between two NPs, you would report 25 in the NP line and 50 in the MA line.

Q: Are there any guides that provide care management recommendations per risk level?

A: Please visit the AAFP website for resources on risk-stratified care management. Included are a couple of examples of risk categories, levels and care plan considerations.

Q: What kind of office space are other practices providing for care managers?

A: Care managers need space to meet privately with patients and families. They need a telephone and computer as well as storage space for patient education tools and reference books. Their space should be conveniently located so that physicians can easily find them and "warmly" handoff patients. Consideration should be given to the future addition of one or more care managers.

Milestone 3: 24/7 Access by Patients

Intent of Milestone 3

Milestone 3 increases access to care while supporting the relationships that lead to improved health outcomes. In PY 2013 CPC practices leveraged the power of the electronic health record to ensure that patients' specific health information is available whenever and wherever it is needed to guide care.

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.

Work Elements for Milestone 3

1. Ensure that patients or other health care providers have the ability to speak with a provider who has access to the practice EHR; making changes to the technology, the processes or the people as needed.
    - The EHR may require an upgrade for secure, remote access at all times.
    - Secure access may require a private network or web- and cloud-based solutions.
    - Expanding privileges and remote access rights to the EHR to designated providers may be necessary.
    - Additional staffing or an after-hours call line with access to the EHR or a protocol for escalation to a provider who has access to the EHR may be needed.
    - Consider joining a call pool of providers and provide access to the practice EHR as appropriate.
2. Consider other strategies to expand patients' access to their care team during office hours as needed.

Documenting the Work in Milestone 3

CPC practices described how they supported 24-hour/7-days-a-week patient access to a nurse or practitioner who had real-time access to the practice's medical record for patient advice as well as to inform care by other professionals. The description included how this access was achieved, which care team practitioners had access and what other services or accommodations (such as shared coverage) made this possible.

Practices' Approach to Milestone 3

Workflow for overnight and weekend access to the EHR for on-call physicians

Peach Valley Family Medical Center, Clifton, Colorado (group practice, four physicians, one PA)

This four-physician practice built technology infrastructure and staffing to allow 24/7 access to the EHR information and to guide care outside of office hours. A PA and other staff were budgeted and added to offer extended service times to patients. The practice uses the services of an RN triage line after hours.

To establish the capability for patients to speak with a provider who has 24/7 access to the EHR, one of our four physicians is on call at all times. A RN triage service (Fonmed) handles administrative and general advice calls, such as medication refills, appointments and calls that require immediate referral to the hospital. All other calls that might otherwise be referred to the ER or an urgent care center are put through to the physician on call. This results in about one to two calls per night or three to four calls on a weekend.

All physicians carry smart phones or tablets with them at all times to access the EHR through the VPN. They document calls as they come in and create a task in the EHR for follow-up, as needed. Fonmed provides a report on any call its staff handles. We scan their report into the patient's chart and the primary care provider signs it.

Smart phones and tablets are linked to a secure VPN. This optimizes the timely access to the EHR, which improves the clinical outcomes of patients who need care services after hours, while making efficient use of limited resources and staff time.

The practice began this process in April 2013, so they only had two full quarters of data available by end of program year 2013. Although their ER visits for the fourth quarter rose by five visits over the third quarter, they expected the number to be even higher due to the time of year. The practice will continue to monitor this process and make changes as necessary.

24/7 EHR Access for Outside Providers Who Share Call Coverage

Foresight Family Physicians, Grand Junction, Colorado (group practice, three physicians)

This three-physician group practice expanded its office hours and staffing to enable access to EHR information and to guide care outside of office hours. They started with evaluating their capabilities at the beginning of 2013, and determined what it would take to meet the objectives of this Milestone. They added four hours to clinic operations per week with Saturday hours from 8 a.m. to noon, and provided two staff members to cover that period of time.

The practice adjusted its technical infrastructure to support 24/7, real-time access to the patient's electronic medical record. By creating a secure VPN (virtual private network) access to the electronic health record, outside providers sharing call coverage for this practice are permitted limited remote access. They can view the patient record but cannot enter data or access financial information.

Online access to the EHR for remote users can leave the EHR vulnerable to hacking. VPN access reduces such risk. After connecting to their local network, the remote user then accesses the application as if connecting to a segment of the local (physical) network. This provides secure and timely access to the medical record.

All staff providers can now securely access the EHR remotely when on call. This includes the practice physicians, nurse and health coach. The practice does not use a nurse call line.

Tools and Resources for Milestone 3

Click here to access the complete list of resources for all Milestones.

Structural workflows, practice guidelines and protocols for expanding patient access to providers were essential tools for this Milestone work.

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.

FAQs for Milestone 3

Below are questions practices asked during PY 2013 as they were completing the day-to-day work of CPC. These frequently asked questions are provided here to illustrate various practice approaches to achieving the Milestones and specifics that needed to be addressed as practices implemented innovative tactics.

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

3.1 After hours or covering physicians

Q: We are a small practice with after-hours coverage by physicians who are in other practices (with different EHRs and not part of CPC). Physicians who cover this practice do not have access to the CPC practice's EHR. Does this arrangement meet the Milestone? We are concerned about giving the covering physicians complete access to the entire system. In addition, the covering physicians do not want to learn a new system. When a physician is on vacation is he obliged to check the EHR if someone is covering for him? Are nurses, who simply triage calls to on-call providers, required to have access to EHR?

A: When good patient care depends on specific information from the patient's record, then that information should be available at any time. That is the intent of Milestone 3. Nurses who triage calls do not need access to EHR as long as the on-call providers have access and the nurse is operating under protocols that clearly indicate escalation to the on-call physician when patient-specific information is needed from the EHR. Covering physicians should have access to the CPC practice EHR, or be able to contact a physician or other staff member who has that access to gain the information they need to provide care. Milestone 3 is about fulfilling the promise of the EHR and allows providers and patients to use information in the EHR when it matters to improve care.

3.2 Urgent care center staffing

Q: We are within a large health care system. Our practice has decided to allocate CPC funds to add provider and staff to urgent care centers within the network to increase after-hours access. Is this an acceptable solution for Milestone 3?

A: PY 2013 Milestone 3 addresses 24/7 real-time access to the EHR by practice providers or those with whom practice coverage is shared so that continuity between the care team and after hours care is maximized. Extended urgent care hours are not required in the CPC PY 2013 Milestones. Whether the extended hours tactic accomplishes Milestone 3 depends on whether there is EHR continuity (and ideally provider continuity) between regular and extended hours.

Milestone 4: Improve Patient Experience

Intent of Milestone 4

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 the patient perspective and engage patients and families as partners in improving care.

Work Elements for Milestone 4

Practices were given the option of conducting brief, in-office surveys or developing a Patient and Family Advisory Council (PFAC).

How Milestone 4 addresses the CPC Change Package

Patient and Caregiver Engagement

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

Patient Survey

- Select two out of the five CAHPS domains for improvement and tracking through brief patient surveys. These can be brief, in-office surveys of convenience samples or more formally administered surveys (see Tips)
- Develop and share an improvement plan designed to improve the patient's experience in the selected domains.
- Administer the patient experience survey at least twice in the last two quarters of calendar year 2013. The survey questions should be the same for both quarters to allow tracking of quality improvement activities over time.

See inset box on next page for tips on creating effective in-office surveys.

Patient and Family Advisory Council

- Form a Patient and Family Advisory Council (PFAC) that meets quarterly (at least twice in 2013).
    - Identify practice team members who will work with the PFAC members.
    - Determine recruitment and selection process for patient and family members.
    - Recruit and select patient and family members using a variety of criteria including but not limited to age, race and gender.
    - Determine and develop operational aspects of the PFAC, including but not limited to orientation, clarifying roles, meeting and communication processes, areas of focus and goals.
- Use work accomplished by the PFAC to inform changes in workflows, processes and policies.

Documenting the Work of Milestone 4

CPC practices described how they undertook the work of engaging patient and family in their improvement endeavors by either describing their methodology and tools for administering the survey or describing their PFAC recruitment and selection methodology. These practices shared either their survey results in a run chart format or their PFAC annual goals and practice changes made as a result of PFAC guidance in PY 2013.

Tips for In-Office Survey

Think of this survey as a way to "hear the voice of your patients" and not as a scientific survey. The process has to fit into the clinic workflow and not create a large burden to patients or staff. At the same time this information must be meaningful and valuable to patients and staff.

Use standardized questions. Good questions provide better answers.

Ask enough questions but not too many. Ask several questions that get at the same area of interest. A good rule is to ask at least three questions per domain, and asking all the items in a sub-group is advised. The complete survey should not be more than 15 questions or one to two sides of a page.

Don't ask if nothing will change. Survey responses should reveal how the changes made in the practice are affecting patients' experience of care. If the responses will not prompt changes, then it's not worth asking the questions.

Keep it current: Ask questions that will show change later on as improvements are made in your practice. The information patients provide should reflect the changes currently occurring.

Ask enough people to feel confident in the answers provided. This is not research. It will be a convenience sample of patients and should not be thought of as statistically representative of the entire patient population. At the same time, survey enough patients to have confidence that the answers mean something. This will vary by practice size.

A common approach is to choose a sample that reasonably represents the population. For example, offer the survey to all patients on Tuesday morning and Thursday afternoon to capture all care teams or providers. Or, randomly survey 30 patients every day for a week, once a month. Try for 50 percent of the relevant population. If a care team sees 100 patients in a week, collecting 50 completed surveys for the week is advisable.

Ask the questions in a way that provides reliable answers. Consider the survey as reliable, direct feedback from patients and strive to encourage honesty. To do this, ensure your patients' anonymity when responding and create some distance between the care team and providers to encourage honest, non-biased responses. A good way to do this is to have the office staff hand out questionnaires at check out or the end of a visit. Provide a sealed box or envelope for patients to deposit their completed surveys. Avoid numbering or "marking" the survey as this may make some patients anxious about their responses being tracked.

Do the questions need to be translated? Practices with a very high population of non-English speaking patients might consider using the translated CAHPS items and the translation guidance located at www.cahps.ahrq.gov.

Don't reinvent the wheel. Some practices, especially those that are part of a larger system, may already be conducting a standardized quarterly measurement. If so, use the data to guide the tests of changes and improvement in care that meets the Milestone.

Readability is important. Use a type size and a font that is easy to read. For example, a 10- to 12-point type keeps the survey to the recommended one page or double-sided. The CAHPS survey standard font is Times Roman, which has been tested and shown to be the easiest to read in a survey format.

Look for trends. A single point in time on the survey won't reveal much. By seeing how the data changes over time, the data points should correlate to the changes made in the practice. While **the requirement for the Milestone is just two quarterly data points**, the greatest benefit of this process is from measuring *more frequently*, for example weekly or several days/month or even every couple of weeks, while changes are being made in the practice.

Make it visible and sensible. Plot the results on a run chart and annotate the run chart with the changes being made. This allows tracking trends over time and any temporal association between the changes being made and the patients' experience of care. The easiest way to analyze the data is by single item. Don't fuss with fancy composites unless you are using a full, formal survey.

Share the results with the patients. Posting the results in a prominent location for patients and staff to see sends a strong signal that the practice is listening.

Practices' Approach for Milestone 4

Developed Both Patient and Family Advisory Council and Patient Survey Options

Dr. Randy D. Walker Family Practice & Allergy Clinic, De Queen, Arkansas (solo physician practice)

This practice is led by a provider and supported by two LPNs, one MA, one x-ray technician, one allergist and four support staff. To identify an area of patient experience to improve, surveys were mailed early in the year to the practice's patient advisory board (PAB) to gather insight into which items could be targeted for improvement. The initial feedback from the PAB suggested that access and communication be targeted for improvement.

Surveys. To confirm early indications from the PAB, the practice mailed surveys with postage-paid return envelopes to all patients who were seen in the clinic during the third quarter of 2013. Total surveys mailed to patients were 839. The practice received 326 completed responses.

For the fourth quarter of 2013, the practice elected to provide patients with surveys upon check in at the office. A basket was conveniently placed for patients to return surveys anonymously. Despite the practice's best efforts, only 78 responses were received. In the future the practice will mail surveys to achieve a higher response rate.

Assessment of Results. The practice used the student resources from a local college to graph the results of surveys from both Quarter 3 and Quarter 4. Quarter 3 results confirmed what the practice initially heard from its PAB, which is that the patients' experiences within our access and communication domains should be targeted for improvement. Quarter 4 results revealed that the practice is making progress but will need to continue focusing improvement efforts on access and communication.

The practice created run charts to illustrate the results. As an example, a run chart was created to reflect the results of answers to two of the survey questions so we could see track changes from Quarter 3 to Quarter 4. For the survey question "Did this provider's office give you information about what to do if you needed care during evenings, weekends or holidays?" the chart's horizontal values represent the responses YES and NO. The values along the vertical axis represent the percentage of those responding YES and the percentage of those responding NO. The lines connecting data points were color coded to differentiate between quarters. The results showed improvement from 67.79% of YES in Quarter 3 to 74.36% in Quarter 4. Quarter 4 results reveals that the practice is making progress, and will continue these efforts.

For the survey question that asked "In the last 12 months, how often were you able to get the care you needed from this provider's office during evenings, weekends, or holidays?", Quarter 3 results for the ALWAYS answer was 5.83% and in Quarter 4, the results improved to 11.54%.

Improvement Actions Associated with Access Domain. To continue improving the patients' experience in the access domain, the practice started offering same-day visits, as well as services through the patient portal. Technical capabilities were expanded by upgrading bandwidth for internet access and to support 24/7 internet access to the EHR. The patient portal, website upgrades and a clinic services brochure support the sharing of information with patients about expanded hours. Staffing was improved by adding a nurse practitioner and nurse triage line.

Communication with patients will continue to be enhanced through the patient portal, Facebook interaction, brochures, and during clinic visits.

PFAC. The practice formed a Patient and Family Advisory Council by identifying community stakeholders and professionals as members. The council met only once in 2013 and will continue to meet in 2014. The practice solicited members to represent the racial/ethnic and age mix of the patient population. The council identified preferred methods of contact (e.g., meetings, email, information sent by U.S. mail). The council's activities include identifying specific content for the practice's website (education, introduction and advertisement), developing instructions on how to use the patient portal, brochure content development, patient education needs and using Facebook for outreach.

Patient Survey Option: Survey Patients Quarterly

Upper Valley Family Care, Troy, Ohio (group practice, six physicians, four NPs, two practice sites)

This practice of six physicians, four nurse practitioners and one LPN focused on improvement within the coordination of care and patient access domains. Upper Valley selected two CAHPS domains for improvement: access and care coordination.

Access—Getting Care Quickly and Evening/Weekend Care. This practice selected the access domain to improve based on comments from patients and their awareness that lead time to schedule certain appointment types was historically too long. Additionally, they ran several PDSAs since the start of the CPC initiative and found an overwhelming majority of patients were unaware of the availability of access to the physicians during evening or weekend hours.

Care Coordination—Specialists and Hospital Follow-up. Care coordination was a new undertaking for Upper Valley. A care coordinator position was added in each practice location to help with bridging the information gap between the practice, referral sources, caregivers and hospitals.

Surveys. Surveys were given to patients one day per week, every week of the third and fourth quarter. The rooming clinical support staff gave surveys to all patients seen by a provider. Once completed, the same support staff collected the surveys and placed them in survey boxes for later review and analysis by an administrative staff member.

Assessment of Results. Results are tallied, entered into an excel file, percentages calculated and then migrated into a run chart format by the administrative staff member.

The results indicated that there were opportunities to improve the patients' experiences of access (getting care quickly for acute type appointments) and after-hours care as soon as needed. There were opportunities highlighted for improvement within the care coordination domain (specifically, improving the patient's experience of discharge from acute or long-term care facilities).

Improvement Activities—Care Coordination. Upper Valley's goal was to improve care coordination for patients discharged from acute or long-term care by adding care coordinators and improving communications with local facilities.

Improvement Plan. Care Coordinators and Workflow

1. A care coordinator was added to staff during the second quarter.
2. Documentation templates were created in the EMR to assist with post-hospital discharge assessments and medication reconciliation.
3. The care coordinators met with community resource organizations to identify services patients could use.

Barriers. Information sharing has been a barrier to improvement. To overcome this, the practice did the following:

1. Encouraged the care coordinators from the two offices to collaborate and meet with the local hospital and nursing homes.
2. Worked with the hospital during the second and third quarters to obtain daily admit/discharge lists, which yielded success in the third quarter.
3. Worked with the hospital care coordinators to improve on information sharing and to receive notification of discharges. Since mid-fourth quarter, the hospital care coordinators have notified the practice's care coordinators of imminent patient discharges.
4. Worked with the local HIE to obtain notification of admissions and discharges from hospitals other than our local hospital.

Patient Access Improvement Plan. Our goal was to shorten wait time to schedule appointments for routine care (wellness and chronic care) by taking these steps:

1. Completed a third Next Available PDSA during the second quarter and the results showed an average 39-day wait for routine appointments.
2. To shorten this wait time, the practice did the following:
    a. Created a new appointment type of "Same Day Appointment" indicating time slots to be reserved for routine care appointments.
    b. Allocated one "Same Day Appointment" slot in the morning and one in the afternoon for this appointment type.
    c. Established scheduling guidelines for these slots to ensure availability.
3. Implemented this test of change with one provider for one month.
4. Repeated the PDSA for the provider involved at the end of second quarter. The PDSA demonstrated success in improved access for routine care. Wait time for routine appointments improved to within three days.
5. Due to these results, the same procedure was implemented for all providers at the beginning of the third quarter.

Tools and Resources for Milestone 4

Click here to access the complete list of resources for all Milestones.

Patient Survey

Practices were encouraged to leverage resources on the Collaboration site for guidance on producing effective surveys that could generate actionable feedback. "In Office Survey Guidance and Tips" (3-page PDF) offers step-by-step processes for implementing surveys including considerations for staff time, readability and sharing results with patients and staff.

Patient and Family Advisory Council

Practices could access learning sessions on the Collaboration site as well as documents that outline step-by-step processes for planning and implementing a PFAC.

Peer CPC practices were frequently featured in the learning sessions, sharing how they operationalized the councils and how they incorporated feedback into the practice to improve the patient experience.

Survey and PFAC Tools

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 patients might ask about the patient surveys.

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 and deliver 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, Slides, transcript and recording from CPC Learning Session, Aug. 25, 2013;
Practices share their approaches to surveying and creating a Patient and Family Advisory Council. .

FAQs for Milestone 4

Below are questions practices asked during PY 2013 as they were completing the day-to-day work of CPC. These frequently asked questions are provided here to illustrate various practice approaches to achieving the Milestones and specifics that needed to be addressed as practices implemented innovative tactics.

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

Q:
1. Should practices produce run charts for each individual survey question obtained over time from in-office surveys, or run charts around their improvement efforts?
2. If there are multiple answers in a single question (e.g., never, sometimes, always), should they include all responses in their chart, or do you prefer a single answer (e.g., always) tracked over time?

A: We'd like practices that are doing in-office surveys to be following this data over time in run chart format - this is the best way to see change over time. A simple before/after look with a convenience sample will be misleading. A run chart gives them a chance to see their data over time and look for trends.

The run chart should use the data that reflects the areas of their improvement efforts. This could be an averaged score across the questions for a specific domain (e.g., if they have 3 or 4 questions that get at the same issue it would make sense to average the response and track it) or it could be a single question on an issue of importance in their patient experience that they are working on (e.g., wait time on the telephone). So they should have two run charts with data that gives them a view of the patient's experience in areas that they are actively seeking to improve.

4.1 CAHPS surveys

Q: We are getting negative feedback from patients on the length (84 questions) of the CAHPS survey. Several patients have expressed significant frustration. Is this common across CPC practices?

A: Yes, other practices have noted patient frustrations regarding the survey length. The survey takes about 15 minutes to complete. Practices should support patients in answering the survey, however understand that for some it may be burdensome. Go to this document on the Collaboration website for talking points.

4.2 Milestone 4A: Administering Practice-based Patient Experience Surveys

Q: What are my two options for meeting Milestone 4?

A: In PY 2013, your practice can choose between conducting a practice-based survey for two quarters (Option A) and forming a Patient and Family Advisory Council that meets quarterly (Option B). If you select Option A, you are responsible for developing and sharing a survey and improvement plan based on the areas targeted for improvement. The patient experience survey needs to be administered at least twice (once each for Quarter 3 and Quarter 4) in calendar year 2013. Use the same survey questions for both quarters to see trends.

Q: What is the difference between CAHPS and the practice-based survey requirement? May we opt out of the CAHPS survey and field our own survey instead?

A: The CMS-administered CAHPS is serving several different functions in CPC, including the independent evaluation, and is a condition of participation: you may not opt out. If you choose Option A under Milestone 4, you will need to conduct an in-practice survey in addition to CAHPS for two quarters. This is a great way to get rapid feedback on patient experience. You should not wait for CAHPS results to begin your surveying activity.

Q: How do we develop the practice-based survey?

A: Initially CMS had planned to have the CAHPS data available to you by mid-year to guide your selection of improvement areas but, because the CAHPS survey results have been delayed, this linkage is not going to be possible in PY 2013. Instead, please select two areas for improvement based on information that you already have about patient experience of care. This might come from prior surveys, patient complaints, informal conversations or more formal focus groups. From there, please choose two CAHPS domains for improvement to focus on from the list in the Milestone Reporting Summary. Then build your own survey based on these domains using standardized questions (e.g., from the CAHPS item bank or other validated survey tool), that address patient experience in your selected areas. CMS gave a webinar on July 10, 2013, about how to build a survey. The transcript and audio files are posted on the Collaboration website.

Q: Are we allowed to use our own questions or just questions from the item bank?

A: You should use some items across two domains from the item bank provided. You may choose to customize questions if there are specific areas of interest or additional questions. You should avoid making the survey too long (more than 10 to 15 questions), and to the extent possible, try to follow the wording and the response formats provided to ease the burden on the respondents.

Q: Does it matter how many questions in each CAHPS domain we choose for improvement?

A: Within each domain, the items are broken down into subgroups. The subgroups can range from one item to many. For example, the very large subgroup of Health Literacy is 13 items. CMS strongly suggests that you take an entire subgroup. The subgroups measure a concept and have been designed and tested to work together. To prevent overwhelming patients and your team, CMS suggests that you look at concepts that cross two different domains, but only choose one subgroup within those domains.

Q: We administer our survey through a vendor, so there is going to be a time lag between doing the quarterly survey and getting the results – for example, the results of the survey for Q4 will not be available until February of next year. Are we going to be able to meet the Milestone?

A: The essence of the Milestone is rapid cycle improvement based on data. Milestone 4A requires you to be able to show two quarters of data by the end of the calendar year and to have begun actively testing changes in their practice based on this data. You may use a vendor but turnaround time is important for the process of testing change.

Q: The CAHPS survey format can be confusing for senior patients to complete ("If yes, go to question 7. If no, go to question 13."). Do we have to use this kind of format for our practice-based survey?

A: No. CMS understands that you will want to make the survey as simple as possible for patients.

Q: We participate with Press Ganey. Can we track that data to meet this Milestone?

A: In general, yes. The Press Ganey surveys are CAHPS surveys. They may make certain adaptations for certain practices. Your team should look at the items themselves and compare them to what is in the CAHPS item bank to see if questions in the item bank respond to certain changes the practice is making.

Q: Can we use our results from the NCQA PCMH CAHPS survey to meet this Milestone?

A: Yes. CMS encourages you to check with whomever is providing that survey, show them what the item bank is, and let them talk with the vendor or the provider about what the goals of this activity are to determine alignment. Practices are strongly encouraged to use well known, validated and reliable items.

Q: Can we use AHRQ Medical Office Survey results to meet this Milestone?

A: This survey is completed by staff rather than patients, so it would not meet the intention of Milestone 4. Milestone 4 is directed at surveying patients and improving patient experience.

Q: Is it acceptable to send surveys electronically?

A: You will want ensure the data you get is broadly representative of your patient population. Online responses may be more highly representative of younger patients. It would be important to look at the data from an electronic survey to see who is responding. It might be prudent to try test an electronic survey along with a paper-based survey to see whether the responders are different and how the responses differ.

Q: We would like to do weekly surveys, but we won't survey the same patients each time. How will we see change?

A: Think of your survey as a convenience sample of the entire patient population you serve. A single view of the data is not that helpful, but you can plot the results over time and see whether there are changes that correlate with the changes you are making in your practice. You do not need to have the same sample each time you administer the survey.

Q: Do the patients identify themselves on the survey?

A: No, survey responses should be anonymous.

Q: Will a run chart template be provided to all CPC practices to track overall survey data?

A: For guidance on run charts, please visit the Collaboration website and locate the July 10 CPC webinar on CAHPS, which provides some guidance about run charts.

The IHI Open School website also has a run chart template tool that may be helpful.

Q: Where can I find a template for an action plan/improvement plan?

A: For Milestone 4 you are asked to provide copies of your action plans for improving upon two CAHPS domains of patient experience. **An example of an action plan template is available in the Collaboration website library.**

An improvement plan (aka Action Plan) is a tool used to document how you intend to improve upon a process or stream of work. While you are asked to provide action plans associated with Milestone 4, action plans are commonly used in quality improvement projects and can be used to help focus your transformation ideas, tests, and implementation throughout the CPC initiative.

The following are elements of an action plan:

A. Statement of the Goals and plans and activities for achieving the goals
B. Statement of what you are trying to accomplish (reason for the change or why improvement is needed)
C. Ideas for tests of change (new process, task, activities, meetings, product)
D. Plans for Plan-do-study-act (PDSA) cycles
E. Plans for assessing progress and
F. Plans for Implementing successful PDSA cycles that lead to improvement

You are encouraged to be creative in designing the format for documenting your action plans.

4.3 Milestone 4B: Patient and Family Advisory Councils

Q: If we choose the Patient and Family Advisory Council (PFAC) option, when should we convene the first group meeting?

A: The PFAC should meet at least twice in calendar year 2013. CMS anticipates that most practices will use the early part of the year to recruit potential participants and conduct internal planning.

Q: Can more than one office within a single health system share the same PFAC? For example, could three offices bring together several patients each at a common location to go over issues that they have?

A: The PFAC is a strategy for engaging patients and families in helping understand how the practice works from a patient’s perspective, and how to make it better. Much of this will be practice-location specific and the greatest value of a PFAC will be if it addresses the specifics of the experience of care at a practice location with those that work there. That said, there is room for adaptation to address both the practice site specifics and the cross-cutting issues that are a result of system-level decisions. One approach may be to ensure that the PFAC has adequate representation from each of the three clinics and that meeting topics specific to each clinic are addressed at each meeting. Similarly it will be important to include staff and leadership from each clinic at the PFAC so that they see the process and understand the insights coming from the PFAC. It is important that the clinics show that the specific experience of their patients in their clinic is addressed and that their specific staff is involved. Moving the whole enterprise to system level (i.e., advising the system leadership) would not be an acceptable way to approach the Milestone.

Milestone 5: Use Data to Guide Improvement

Intent of Milestone 5

Milestone 5 guides a systematic approach to using practice data to improve care. In PY 2013, practices identified quality and utilization measures of importance to the practice and its patients, and used that data as a guide for testing practice change.

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.

Work Elements for Milestone 5

1. Identify **one quality measure** on which to focus improvement efforts (e.g., colorectal cancer screening, breast cancer screening, Beta Blocker therapy for LVSD).
    - Select a measure supported by the ONC-certified EHR or any NQF-endorsed measure.
    - Choose the measure based on its clinical importance and/or improvement potential.
2. Identify **one utilization measure** on which to focus improvement efforts (e.g., hospitalizations for any cause, potentially preventable ER visits, imaging services).
    - The actual report on utilization for this measure could come from payers or local data. Local data may be less complete but will be timelier and therefore more responsive to test of change.
3. Collect practice or provider-level data over at least **three quarters on the selected quality and utilization measures**.
4. Display the data for use in guiding improvement. As an alternative to numerator and denominator submission, consider a run chart for display.
    - Charting data monthly shows trends more quickly and guides more frequent testing of changes, accelerating improvement.
    - Consider posting run charts in a public place to let everyone know that the practice is engaged in improving quality.
5. Use this data to give a view of the performance of the practice on the measure, and test changes designed to improve performance.
    - Set a goal for performance improvement (important to determine direction)
    - Conduct small tests of change using PDSA cycle methods, implementing when there is confidence that the changes tested are leading to the desired results.

Documenting the Work in Milestone 5

CPC practices generated and reviewed at least quarterly practice- or provider-based reports with a minimum of one quality measure and one utilization measure. Practices had two choices for selecting measures:

- Measures selected from the list of Clinical Quality Measures that practices report to CPC
- Any NQF-endorsed measures based on clinical importance and/or improvement potential

Practices provided three quarters of data and described at least two sequential tests of change based on the data results.

Practices' Approach to Milestone 5

Integrate Milestone 7 (shared decision making) focus with Milestone 5 quality measure (colonoscopies)

Batesville Family Practice Clinic, Batesville, Arkansas (group practice, six physicians)

At Batesville Family Practice Clinic, six physicians and one registered nurse are involved in managing the care of patients. For Milestone 5 the practice focused on Colorectal Cancer Screening (NQF# 0034) as the clinical quality measure and the ER visits/Observation stays for any cause as the utilization measure.

Changes Affecting Clinical Quality Measure. The first test of change identified was to choose and create the decision aid relating to Colorectal Cancer Screening. After several reviews of different decision aids, one was created from evidence-based practice sources.

The second test of change identified was changes made in flagging patients eligible to receive a decision aid, tracking decision aids received by patients, and the decisions made by patients after reviewing the decision aid. The practice was able to track and report on the number of patients eligible to receive decision aids, the number of patients who accepted and received a decision aid, and the number of patients who made a decision choosing a test/procedure from the decision aid.

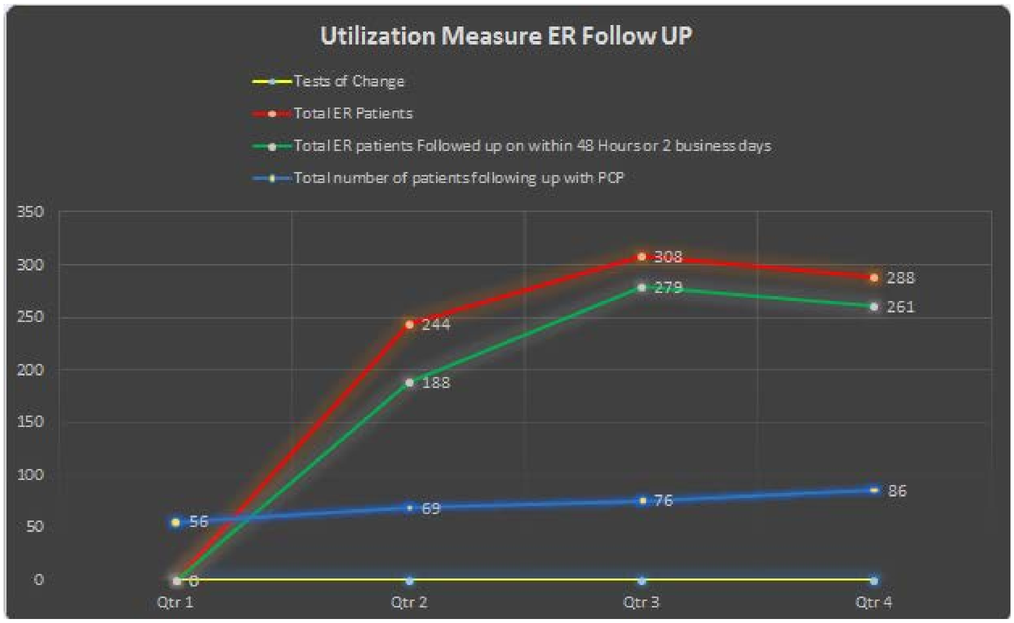
The third test of change identified was changes made in the workflow to consistently obtain reports from patient procedures and have those reports available for physician review. The practice had to select an area in each patient's chart to consistently document the last completed preventive tests/procedures, which assisted the staff and the patients in knowing when preventive tests were due. The process is as follows: as orders are placed for procedures, a reminder is placed to follow up with the referring physician to request the report from the procedure. The report should then be available for the primary care physician to review and make recommendations.

The fourth test of change identified was to add a reminder to follow up with patients to schedule repeat procedures as recommended by the physician, based on the current test results. As patients are due for a repeated procedure, they are contacted and scheduled for that procedure per their PCP's recommendations.

Utilization Measure—Change Related to Protocol. After choosing ER visits/Observation stays for any cause as a utilization measure to improve upon, the practice created a protocol and workflow to apply tests of change. Every patient discharged from the ER who is categorized as medium or high risk received a follow-up phone call. During this call, their medical and care needs are assessed. Positive responses were received from patients due to follow-up interactions they had after their ER visit. Patients in need of further instruction or education were identified and these needs were addressed. As a result, both the number of patients who followed-up with their PCP and the continuity of care activities increased.

Change Related to Tracking Documentation. Changes were made in the EMR to track the number of ER patients, and the number of ER patients who were discharged and with whom the practice followed-up on within 48 hours or two business days. Changes were made related to improving the PCP's access to patient reports from the ER visit. The practice identified easier ways to document data to report the number of ER patients and the total number of ER patients being followed-up on per practice protocol. ER reports and pertinent documentation were available to PCPs in a more timely fashion to improve continuity of care.

Change Related to Effectiveness of Post-Discharge Follow-up Phone Call. The practice identified a structured way to track the number of patients who followed-up with their PCP after receiving the practice's ER discharge follow-up phone call. Future assessment of the data collected may provide insight to improve ER follow-up phone calls.



The run chart shows the improved numbers across all quarters.

Tools and Resources for Milestone 5

Click here to access the complete list of resources for all Milestones.

Utilization Reports. The Innovation Center and other payers provided cost and utilization reports quarterly. Many practices chose to collect local data which, while less complete, was timelier. Practices often linked the utilization measure for this Milestone with Care Coordination activities in Milestone 6.

EHR Capacity. Most EHRs have the capacity to generate quality reports. The work in this Milestone was distinct from the CPC requirement to develop capacity to use and report on the Clinical Quality Measures at a practice level.

Improvement Series. The Fall 2013 Enrichment Opportunities included a series of webinar presentations focused on the basics of quality improvement strategies. Slides, recordings, transcripts and additional tools from each presentation are posted on the Collaboration website and linked below.

Tools

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.

FAQs for Milestone 5

Below are questions practices asked during PY 2013 as they were completing the day-to-day work of CPC. These frequently asked questions are provided here to illustrate various practice approaches to achieving the Milestones and specifics that needed to be addressed as practices implemented innovative tactics.

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

5.1 PQRS

Q: For CPC purposes are mid-levels eligible professionals?

A: For CPC purposes, as it relates to PQRS waiver, practices should follow the PQRS EP definition. The link is in the CQM manual, on the program "About" page and in the Library.

5.2 Reporting on use of data to guide improvement

Q: Does the entry of numerators and denominators for the 2nd, 3rd and 4th Quarters for the utilization and quality measures need to represent the aggregated data for each quarter or can it be just any one month out of each quarter?

A: The measures for Milestone 5 should all be measures that your practice is actually using to guide its efforts to improve quality of care and affect utilization, for example, by increasing access to primary care or reducing unnecessary ED visits or preventable hospitalizations.

Your practice should start to use measurement at the practice level to guide your improvement work and should actively test changes that affect both quality and utilization. Milestone 5 sets a low bar – at least a single measure each quarter – so that CPC practices that have not been using data to guide improvement will put their foot in the water. It is expected that most practices will want to see the quality measures that they will be reporting on more frequently (monthly) at a practice and panel level and will link their utilization measure to the changes they are testing in care coordination or risk stratification and care management. Examples of this are on the Collaboration website, such as the suggestion that three-month aggregated data will not be very sensitive to changes that the practices are testing and would not be effective in guiding improvement.

5.3 Quality Measure

Q: If we are required to report on practice level data, and this data must come from ONC Certified EHR, why are practice level reports not in the ONC Certified EHR?

A: The data reported for clinical quality measures must reside in the certified EHR technology, but practice level reports are not part of the ONC certification criteria.

Q: You answered a question about custom reports and your answer seemed to indicate that CUSTOM reports that pull data out of an ONC certified EHR, are in fact PERMITTED. Please clarify further. For example, can we build a report using the NQF criteria that pulls data out of ONC certified EMR from a practice partner and creates a report in PPR Net and use that report?

A: Custom reports that achieve the function of pulling the data or filtering the data from the certified EHR such that it is represented at the practice level instead of the EP level are fine. As we stated previously, creating reports that simply add the individual results for each EP in the CPC practice site is NOT practice level reporting and is not acceptable.

Q: We have two CPC sites comprised of urgent care and family practice patients. Some of our urgent care patients do not use our facility as their PCP. They see us for ONLY urgent care. How do we pull out our patients who do not use us as their PCP when we report on CQMs? Our system cannot differentiate from the Family Practice and Urgent Care.

A: CPC has defined the focal population for the CQMs as all patients with at least one visit at the CPC location in the measurement year. There are a number of CPC practices that see patients at their locations for reasons other than primary care by a CPC provider and whose visits are co-mingled in the EHR and not readily segregated at this time. These types of visits include:

- Urgent care/walk-in care
- Specialist care (e.g., ob/gyn, dermatology)

Practices have expressed concern that patients seen only for urgent care or for care from a specialist at their site are not within the intent of the CPC CQM yet they fall within the CPC definition of “having been seen at the practice site” in the measurement year.

For measurement year 2013, practices should include all patients who were seen at least one or more times at the CPC practice site location. This is the population of patients who are eligible to be included in a CQM. They will only be included in the measure if they also meet the denominator inclusion criteria specified in the measure. Therefore, any patients seen at your CPC practice site who do not meet the specific type of encounter or age inclusion criteria as specified by the measure to be included in the denominator population will not be included in the EHR measure results. After discussion with a number of practices, CMS believes that any expansion in population (denominator) for these non-primary care visits will be minimal and will not materially affect measure reporting rates.

Q: Our EHR vendor has assured us that we will be able to perform CPC site-level reporting next year, but we have not been able to do so this year. How do we complete the Quality Measure part of Milestone 5?

A: In Milestone 5, CMS is interested in evidence that your practice is actually using quality data to guide improvement. You could look at Eligible Provider level EHR data or even claims-based data to meet the Milestone in PY 2013 (but NOT to meet the CPC Clinical Quality Measure reporting requirements).

Q: Will CPC reporting on hypertension require the detail that reporting for PQRS does? PQRS has four requirements for reporting (such as, if blood pressure is over 140/90 do this; if below, do that).

A: The clinical quality measures collected as part of CPC will be consistent with the measure definitions used in the Meaningful Use program. But quality measure reporting does not define how a practice must manage hypertension. You should test changes that will lead to improvement in these measures, but the measures themselves do not dictate the changes you test.

Q: How should we manage measures 9 and 10 (Ischemic Vascular Disease and Heart Failure, aka IVD) with an ambulatory EHR that is not interfaced with the hospital EHR? Since it involves a complex algorithm or decision tree, how should we address this challenge?

A: 1. For the Measure NQF 0075 IVD (Complete Lipid Profile): patients are included in the denominator for this measure if: They are 18 years and old, had a specific type of encounter during the measurement period, and have an active diagnosis of IVD or were discharged alive after acute MI, coronary artery bypass, or percutaneous coronary interventions. You do not need to have an interface with the hospital from where the patient was discharged, as your EHR should identify this patient if he had the appropriate encounter during the measurement years, is 18 years or older, and has an active diagnosis of IVD.

2. NQF 0083 Heart Failure: Beta Blocker Therapy for LVSD is similar to NQF 0075. The EHR will include the patient in the denominator of the measure if the patient is 18 years of age or older, has a diagnosis of heart failure before the start of the measurement period, meets the encounter criteria in the measure, AND either has a diagnostic ejection fraction result less than 40% OR a diagnosis of moderate or severe LVSD OR a diagnosis of left ventricular systolic dysfunction (moderate or severe). Again, your EHR does not have to have an interface with a hospital to capture this information.

Q: If we do not have an electronic feed from hospitals to the EHR regarding diagnostic services patients receive at the hospital, but rely on scanned results, how do we develop an automated method in the EHR to capture those services as structured data?

Our workaround is a manual process where either the person reviewing the scan enters the result in a selected data field (once he finds it in the EHR) or having a regular schedule in place where we run a report of the CHF patients and look for the scanned result and then enter it into the field.

A: The proposed solution sounds viable. In addition to an actual diagnostic study result, the other way patients can be counted in the denominator is through a diagnosis. The following are included in the measure specification for NQF 075: active diagnosis of moderate or severe LVSD OR active diagnosis of Left Ventricular systolic dysfunction (severity: moderate or severe).

Q: Where can we double check all of the inclusion/exclusion criteria for the 2013 CQMs?

A: The CPC EHR CQM instruction guide is located on the CMS Collaboration web site. It is located on the "Program Home" page.

5.4 Utilization measure

Q: For Milestone 5 utilization measures, is there an approved list of measures to choose from?

A: The claims-based reports that practices will begin to receive spring of 2013 from CMS for Medicare Fee for Service beneficiaries includes the following utilization measures:

G. Hospitalizations for any cause
H. Hospitalizations for ambulatory care sensitive conditions (ACSCs)
I. ER visits/Observation stays for any cause
J. Potentially preventable ER visits
K. Specialty care provider services
L. Laboratory
M. Imaging

You may choose one of these measures, especially if the CMS data is the only data you have. As part of the Memorandum of Understanding for CPC, all payers are committed to providing cost and utilization reports to participating practices and aligning these reports over time. These early reports might not all look alike or have the same metrics. If you have local multi-payer utilization measures available at a more frequent interval, you can also guide practice-level changes using that data.

You are also free to develop your own measure for this Milestone (e.g., ED visits during office hours) if you have the data sources. For example, you could identify a claims-based measure of utilization with which to correlate your own, internally derived, intermediate process measure that you use to guide changes. This could be a measure such as whether the hospital actually supplied ER data in a timely way, whether a follow-up contact was made in 72 hours, and whether the responsible care manager actually reached the patients whom she or he was intending to reach. The idea is to point you in the right direction of the important intermediate process steps that can affect the claims-based measures.

Q: Will it be a problem if we pick a utilization measure from only one payer? This will be an incomplete picture of our population.

A: No, this is not a problem this year. We understand that for this Milestone, the data sources will be incomplete at present.

Q: We have not received utilization data from all our payers. For reporting purposes should we leave out those patients from both the numerators and denominators or should we upload our own data?

A: You can use measurements at the practice level to guide your improvement work in Milestone 5 if you chose a measure that does not include data from all payers. For instance, you may choose to use a measure where you only have CMS data to guide practice-level changes. The design of this measure would include reporting the numerator and denominator applicable to that data source. We realize that some data sources will be incomplete. The point is for you to take steps that affect claims-based measures.

Q: We are considering using hospital readmission rates as our utilization measure for Milestone 5. The hospital has an internal hospitalist program where we can track 30-day readmission rates for all patients cared for by the hospitalist program. Would this meet the Milestone?

A: That is an excellent utilization measure for Milestone 5. It uses locally obtained data that can guide efforts to reduce readmission rates.

Q: We would like to track "office visit post-hospital discharge within seven days." Is this an acceptable measure?

A: The utilization measure cited would be appropriate, providing you have or build a process to track it.

Q: Are there specific parameters for the "other" option for the utilization measures, such as writing in the NQF #?

A: When selecting "other" for utilization measures, please provide as much detail and specifications as you can on the origin of the measure, including the NQF#, if applicable.

Q: Please provide some clarity on expectations between Milestone 5 and Milestone 6, specifically around the reporting on utilizations (5) and reporting for care coordination (6). There seems to be overlap in what we are being asked to report on.

A: Milestone 5 asks you to use data to guide improvement, identifying at least one quality measure and at least one utilization measure, testing changes in the practice and using those measures to see if the changes are resulting in improvement. You should focus this improvement work in areas that are important to your practice – making changes where it matters to you and to your patients. It makes sense (but is not required) for you to choose a quality measure that is part of the EHR-based quality measure set for your region.

Milestone 6, on the other hand, asks you to identify an area of care coordination or coordination across the medical neighborhood, and work to improve it. For example, ED follow up, hospitalization admission or discharge, or medication reconciliation after hospitalization. Your practice should identify, develop or select a measure that will guide your work, such as a measure that will tell you whether the things you are doing (testing of changes) is actually improving care coordination.

It may make sense (but is not required) to choose a utilization measure for Milestone 5 that your Milestone 6 work will affect. An example of this would be reducing ED visits following hospital discharge as the utilization measure for Milestone 5, and measuring timely ED follow-up as a care coordination improvement project for Milestone 6.

Q: Could we track generic prescriptions (provider is prescribing generic meds, rather than leaving it up to the pharmacy to decide) and virtual office visits as utilization measures?

A: Yes. The use of appropriate generic medications and alternate visits (virtual visits), are important strategies in achieving the aims of Comprehensive Primary Care and make great sense as a utilization measure under Milestone 5, providing you are able to obtain the data to guide these improvement efforts.

Milestone 6: Care Coordination

Intent of Milestone 6

Milestone 6 work addresses systematic coordination of care across the medical neighborhood. In PY 2013, practices built relationships with willing partners to improve coordination of care.

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.

Work Elements for Milestone 6

1. Identify one area of care coordination on which to focus improvement (e.g., notification of emergency room visits at local hospitals in a timely fashion).
2. Identify a measure that will reflect improvement (e.g., the percentage of patients seen by selected ED(s) for whom the practice receives notification within 48 hours).
3. Reach out to the provider or institution to establish a plan for improving coordination.
    - Some CPC practices worked together to reach out to a hospital that admitted many of their patients.
4. Monitor the measure of care coordination to assess impact and use this data to guide continued testing.

Documenting the Work in Milestone 6

CPC practices demonstrated active engagement and care coordination across the medical neighborhood by creating and reporting a measurement to assess impact and guide improvement. The measurement included numerator and denominator data.

After identifying the area for improvement for care coordination, the practices described the improvement opportunity and tests of change and showed how they tracked these changes with metrics that they defined.

Practices' Approach to Milestone 6

Care Coordination to Reduce Readmissions

Willamette Health Partners, Salem, Oregon (system)

This group began compiling a community-based resource guide for its practices several years ago, but only when a risk stratification process and a care management team were in place was its full potential for patients realized, specifically resulting in improved end-of-life care and lowered costs for at least one patient.

Sharing the Risk Stratification Process. Willamette Health's CPC practices use a four-stage stratification derived from materials provided by Oregon faculty, and providers adjusted it to fit the practices' patient panels. It is embedded in the practice's EMR (EPIC) and all practice sites (not just the two CPC sites) risk stratify e their patients.

During the early stages of working with the risk stratification tool, the practice found the low-risk categories were too broad. Working with their information technology team, they altered the scoring methodology to weigh the diagnoses and still have a meaningful, stable scale to share across all sites.

A specific area of interest is identifying patients at risk for moving into a high risk category but who also may respond well to targeted interventions.

Because the tool easily identifies patients who are at high risk of hospital admissions, three hospitals that admit patients from this practice are interested in sharing the tool. At this time, one hospital notes patients' risk stratification score on admission, and when the patient is discharged, the score is updated and communicated back to the practice. The other two hospitals are working through IT challenges to integrate the risk stratification scoring within their systems.

Other practices may consider working with hospitals to identify diagnoses or other conditions that are priorities in the hospital's reduction of readmissions initiatives. Including the hospital's priorities in the practice's risk stratification process may encourage cross-community collaboration.

Care Management Post-Hospitalization. When care managers and advice nurses at Willamette follow-up with patients discharged from their partner hospital, they can work from the newly updated risk stratification score.

This timely information, along with the practice's database of community resources, helps them manage the patient's immediate medical needs as well as connect them to services in the community that can fill in other gaps that create re-hospitalization risks.

Putting It All Together. One story illustrates how the timely flow of information and availability of resources eliminated a series of avoidable hospitalizations and improved end-of-life care for one patient. This patient had a terminal diagnosis but no access to medication services outside of the hospital. A prior plan to admit the patient to a skilled nursing facility for IV medication therapy did not work, and the patient was continually readmitted for medication services. Furthermore, the patient expressed a desire not to die in the hospital.

Once the practice and hospital were sharing the risk stratification scores, the hospital admissions team identified the patient as a readmissions risk and alerted the practice about the patient's specific circumstances. Prior to discharge, the hospital's case manager coordinated with the practice's care management team and located an adult foster home that could also provide the medication services. At discharge, the patient was admitted to the foster home and later died there.

Guide Improvement in ED Follow-up Phone Call or Visit

Summit Family Physicians, Middletown, Ohio (group practice, three physicians)

This practice started its improvement effort on ED follow-up phone call or visit by first assessing why patients were seen in the ED rather than the physician office. They found the following as the most probable causes for inappropriate use of the ED:

- Patients were unaware of the practice's office hours.
- Patients may have a financial issue with physician office, such as outstanding balance or an inability to pay.

- Patients use the ED out of habit.
- Specialists may send patients to the ED when specialists' appointments are unavailable.
- Patients may identify Summit as their primary provider at the ED, when the patient is inactive or has never been seen by the practice.

Reaching Out to Key Hospitals in the Community. Summit Family Physicians established an agreement with Atrium Hospital, the most frequently used hospital among the practice's patients, to create a communications process. The hospital agreed to send discharge reports for Summit patients within 24 to 48 hours of discharge or ED visit. A similar agreement was reached with Cincinnati Children's Hospital for Summit's pediatric patients.

Discharge reports from Children's are faxed to the practice, where they are scanned into the EMR. Atrium and Summit share an HIE link, and discharge reports are sent electronically. A configuration issue in the HIE prompts a new report whenever records are updated or signed off, unfortunately resulting in a redundancy of reports sent to multiple providers. This process is targeted for improvement in a future effort.

Setting Up the Measure. Summit tracked ED utilization for the last year, starting in August 2013. From February 2013 onward, Summit tracked outreach to patients in the EMR, and reported on those patients admitted to Atrium Hospital.

Numerator: Patients called after ED visit and assessed
Denominator: All patients with an ED visit

Calling patients within 72 hours of their ED visits is captured within the EMR when a phone call encounter is signed and transition of care is marked in the EMR. A report can be generated which captures these encounters as the Numerator. The denominator is derived from a quarterly hospital report.

Improvement Strategies. The key component was establishing the communication link to the primary admitting hospitals for the practice's patients. While the effort is expanding to include other area hospitals, Atrium admits the majority of Summit's patients. Improved and sustained communication with this facility poses the greatest opportunity for improvement for the practice's patients.

Knowing the key drivers to inappropriate use of the ED also helped the practice set up a response plan when contacting patients post-discharge. Having the tools and resources to address the patient's concerns immediately during the post-discharge call assures the t patient that the practice is ready and able to provide care. It further assures the patient that the practice is concerned about the patient receiving the most appropriate and timely care.

When discharge notifications are received at the practice, an RN is assigned to call patients within 72 hours. The staff has been cross-trained, and if an RN's workload could compromise the 72-hour window, other staff can step in to take on these tasks.

When the RN contacts the patient, she coordinates care, reconciles medications and identifies the barriers that prompted the patient to use the ED and offers education and solutions for the patient:

- If the patient is unaware of the practice's office hours, she provides that information.

- If the patient had a financial issue, she has the business office offer payment options.
- If the patient uses the ED out of habit, she educates the patient when it's most appropriate to use the ED and why the physician office may be a better choice for medical and financial reasons.
- If a specialist sent the patient to the ED, she reaches out to the specialist's office to provide information about after-hours care.

To educate all patients about appropriate treatment options, the practice prominently displays information on the practice website, on the patient portal and in printed materials in the office. Topics covered in these resources are daily open access, expanded hours, Saturday hours and the provider call line.

Test of Change. To measure the improvement achieved, the practice tested the effects of calling all patients who are known to have had an ED visit to assess their care. The run chart compares all patients called by the RN following an ED visit to Atrium Medical Center to the total number of patients who had ED visits at Atrium Medical.

Improvement Results. From January 2013 through December 2013, ED visits per month to Atrium Hospital decreased (see run chart below). In 2012, 1,815 of the practice's patients used Atrium Hospital's ED. In 2013, the number of patients utilizing the ED was 1,655, a decline of 160 patient visits. Despite an increase in patient population, the number of visits has decreased each month.

The decrease coincided with the increase of follow-up phone calls to patients with an ED visit. Several factors influenced this outcome:

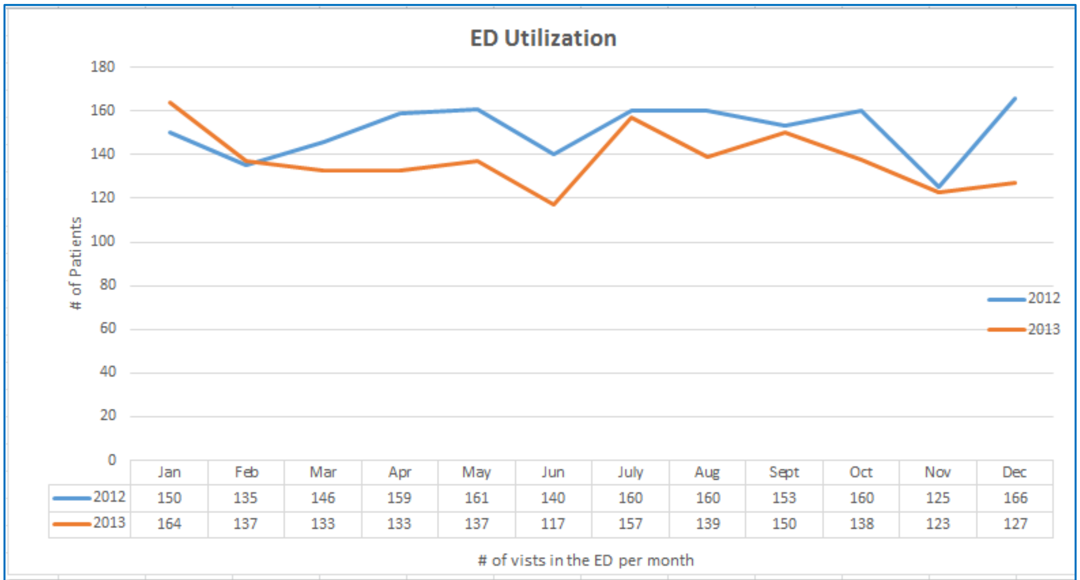
- The practice does not call patients who are already scheduled for a follow-up appointment. This may reduce the numerator.
- The practice can directly admit patients to the hospital because their physicians admit, attend and care for their patients daily in the hospital. The practice admits one-third of its hospitalized patients directly to the floor from the practice's office, bypassing the ED. This has had huge cost savings for the patients. This decreases the denominator (patients who visit the ED).
- A provider is on call 24/7, which allows increased triage of the emergent/appropriate cases for ED utilization and treatment of the non-emergent patients until they can follow-up in the office next day. This decreases the denominator – those patients who visit the ED.

Progress must be monitored over several years, but initial response is encouraging. This practice assesses that they are at the lowest 25 percentile in ED utilization when reviewing Medicare utilization patient data.

Continuing Improvement Opportunities.

- Continuing to educate patients about appropriate ED use.
- Educating patients on available payment plans. Patients can meet their financial obligations and have continued access to the practice's providers.
- Communicating to specialists about office hours, additional access and encouraging them to refer patients to the office when medically appropriate.
- Continuing to build relationships with surrounding hospitals to receive all patients' ED discharge reports within 24 to 48 hours.
- Assessing and treating patients on an outpatient basis when appropriate.

Run Chart: Shows decrease in ED visits to Atrium Medical Center after post discharge phone call intervention initiated in January 2013.



	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
2012	150	135	146	159	161	140	160	160	153	160	125	166
2013	164	137	133	133	137	117	157	139	150	138	123	127

2012 - # of patients seen monthly in the ED at Atrium Hospital (Pre- Intervention: Blue line)
2013- # of patients seen monthly in the ED at Atrium Hospital (Intervention: Orange line)-- calling patients after every ED visit and educating on open access and appropriate ED Utilization.

Tools and Resources for Milestone 6

Click here to access the *complete list of resources for all Milestones*.

Utilization Reports. Practices used claims-based cost and utilization reports to identify improvement opportunities, such as if their patients' ED utilization was notably high.

Collaboration website. The program posted learning sessions and webinar recordings on the Collaboration website about care coordination, and highlighted the opportunities to develop communication channels or other information pathways that encouraged timely and effective information flow among providers.

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.

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.

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. Includes the documentation process and lists responsibilities by role.

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.

FAQs for Milestone 6

Below are questions practices asked during PY 2013 as they were completing the day-to-day work of CPC. These frequently asked questions are provided here to illustrate various practice approaches to achieving the Milestones and specifics that needed to be addressed as practices implemented innovative tactics.

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

Q: If we want to track ED follow ups and there are four community hospitals where our patients may go, must we obtain ED visits/admissions data from all of these hospitals?

A: The measure used to track progress for this Milestone does not need to be community-wide but can focus on the hospital(s) where the majority of your patients are served.

Q: What is considered "potentially preventable"? Is it the chief complaint or time of day?

A: The Medi-Cal list of ICD-9 codes can be used to retroactively look at patients' ED visits. You can enter reports received from local hospitals into your HIT or EHR system and use a database to check whether the ED visit was for any of the ICD-9 codes on the Medi-Cal list. If a visit proves to be potentially preventable, you can look into the visit notes to gather information, such as the time of day and whether the on-call physician instructed the patient to go to the hospital. Some of the information from the hospitals does not include ICD-9 data, so you may also want to review visits that have that information missing. New York University offers another way to calculate avoidable ED rates using this algorithm.

The Washington State Hospital Association website offers extensive tools and resources as well.

6.1 CPC Coordinator and Care Coordination

Q: We are tracking referrals for care coordination. The process begins from the time the referral is initiated and ends when the report comes back to the provider. Due to our rural location, this can take several months. Therefore, we have reported our data quarterly, but we have had to use a rolling six-month look back period to identify any valuable information. Is this an acceptable strategy?

A: Yes, your strategy is an acceptable one because the issue of lag is inevitable for these types of data reports. Report the data quarterly in the way that makes most sense to you.

Q: For Care Coordination, if we focus on post-hospital discharge visit, do we consider all discharges, including patients who are directed to follow up with a specialist? For example, a patient discharged after a total knee replacement or discharged from a psychiatric hospital? What about patients discharged from the hospital to a nursing home? Should we contact those patients also?

A: It is at your discretion how you focus on a population of post-hospital discharges for this Milestone. Milestone 6 asks you to identify the challenge or problem your patients are experiencing in one area of care coordination and determine specific aims for a care coordination improvement plan. You define the opportunity for improvement. So, if you selected to improve care coordination for patients discharged after a total knee replacement, then other post-hospital discharged conditions might not be included in your care coordination improvement plan or tracking at this point.

6.2 Eligible Transition of Care CPT billing codes

Q: Can we bill for the Transition of Care (TOC) CPT codes 99495 and 99496?

A: Yes. CPC practices can bill for TOC using the appropriate CPT codes.

Milestone 7: Shared Decision Making

Intent of Milestone 7

Milestone 7 focuses attention on ensuring that patients and families receive the information they need to be engaged, informed and effective partners in their own health care. Practices integrated the process of shared decision making (SDM) and the use of decision aids into the clinical workflow; providing information in a way that enables patients and families to identify their health goals and priorities and bring that understanding into the decision-making process with their provider.

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.

Work Elements for Milestone 7

Select one decision aid in an area of priority to the practice, and then implement this decision aid into the practice workflow. Monitor the use of this decision aid to understand how well it is being integrated into the practice.

1. **Select a priority condition.** Identify a preference-sensitive condition, one in which there are two or more potential testing or treatment options, highly influenced by patient values and preferences (e.g., acute low back pain without red flags).
2. **Select a validated decision aid for the priority condition**: The Collaboration website offers links and examples of validated tools to help patients make good choices for their health care with the use of decision aids. For example, the Agency of Healthcare Research and Quality offers numerous decision aids. CMS does not endorse any particular source for decision aids.
   These evidence-based aids facilitate the process of shared decision-making with patients who are involved in making an informed, values-based choice among two or more medically reasonable alternatives or options. The decision aid should help the patient clarify their thinking and reflect on their own preferences and values as it sets the stage for a conversation about options for care. The workflow for the shared decision making process should allow time for patient reflection and deliberation before a decision is made in conjunction with the provider.
3. **Integrate the selected decision aid into the your practice workflow**:
   - Develop a process for identifying the patients who are likely to benefit the most from this aid. The ONC-certified EHR allows maintenance of a registry of patients for a specific priority condition.
   - Describe the process for determining when and how to introduce this aid to the patient.
     A process map (workflow diagram) can be very useful, and may be guided by these questions:
     - Who are the staff involved with identifying patients, introducing the aid and its purpose, explain the process?
     - Where and when will the patient review the decision aid?
     - How does this integrate with the patient's visit with the provider?

Documenting the Work in Milestone 7

CPC practices identified a priority condition, decision or test that would benefit from shared decision making and the use of a decision aid. They made a decision aid available to appropriate patients and described how they generated a metric for the proportion of patients who received the decision aid for this priority area. Practices shared a process map or a narrative description of how the practice embedded use of the decision aid into the flow of clinical care.

Practices’ Approach to Milestone 7

How to Include and Document Shared Decision Making Tools into Workflow

Freeman Family Medicine, Conway, Arkansas (group practice, two physicians)

The practice selected PSA test for prostate cancer screening as the priority area for Shared Decision Making (SDM). The physicians and staff researched available SDM tools, and then selected a PSA tool produced by the American Cancer Society. We felt this tool was the most credible, least biased and most informative for helping patients and physicians intelligently discuss the PSA testing and implications for the patient.

Clinical staff were trained on how to use the tool appropriately. Copies of the tool were printed and laminated, and then placed in each exam room.

Workflow. After obtaining vital signs on an eligible patient, the nurse determines if a PSA had been done within the last year. If not, then she hands the patient the decision aid tool to review ahead of the visit with the physician. When the physician enters the room, the patient, who had reviewed the material, would be able to discuss this test with our physicians.

The physician would then, based on the conversation with the patient, either order testing and record the date of testing in the patient’s chart, or enter a status of “declined” in the Health Maintenance section of the EMR. The EMR saves this data and will prompt the clinical staff next year to revisit this option and have this discussion again with the patient. Until introducing the decision aid, the staff did not use the health maintenance field designated for PSA testing.

Rates of Use. The health maintenance report for PSA testing displays all patients who meet the assigned criteria for potential PSA testing (all males age 50 to 75 years). Entering data into the field is now a standard step in the clinical staff’s workflow, and it can be assumed that all patients eligible for testing have received the tool and the test was either accepted or declined by the patient.

Process for Choosing a Shared Decision Making Tool Related to Diagnosis of Diabetes and Training Staff

Marc Feingold, MD LLC, Manalapan, New Jersey (solo physician practice)

We selected patients diagnosed with diabetes as a priority area for SDM. We chose to use the diabetes description cards from the Mayo Clinic as our SDM aid. They are incredibly useful in showing the different care options for patients with diabetes.

Workflow. This decision aid is used with all patients who are newly diagnosed with diabetes, along with any patient who has uncontrolled diabetes requiring a change in medication (A1C of > 8). Patients see the options for treatment, based on price, side effects, daily sugar testing, their daily routine and weight change. The practice's RN, who is currently completing certification as a diabetes educator, engages patients in the exam room after their visit with the physician. She spends extra time to answer any questions or concerns patients may have relating to their decision for care.

Rate of Use. We created a place in our EMR to record when the shared decision making tool is used with a patient or given to a patient to help them further understand likely outcomes of various treatment or self-management options. The EMR can produce reports of patients who are eligible for the shared decision making tools, those patients newly diagnosed with diabetes or whose hemoglobin A1C >8, and those patients with whom the tool was used. For the reporting year of 2013 the rate of using this tool with eligible patients was 17%.

Tools and Resources for Milestone 7

Click here to access the complete list of resources for all Milestones.

The CPC program provided national and regional learning opportunities about training staff in shared decision making and incorporating the SDM process into the practices' clinical workflow. CPC practices shared their experiences and processes during these learning sessions.

Tools

Integrating Patient Decision Aids into Primary Care Practice (71-page PDF)
Oregon Rural Practice-Based Research Network produced this Shared Decision Making tool kit, 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 tool kits 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 patient 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 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.

FAQs for Milestone 7

Below are questions practices asked during PY 2013 as they were completing the day-to-day work of CPC. These frequently asked questions are provided here to illustrate various practice approaches to achieving the Milestones and specifics that needed to be addressed as practices implemented innovative tactics.

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

7.1 Broader explanation of Milestone 7

Q: Please explain Milestone 7 (shared decision making).

A: One way to think about shared decision making is as a function of primary care that ensures patients get what they want—not more and not less—through an informed conversation exploring the evidence and the options. It can and should be a part of all aspects of medical care. Milestone 7 asks that CPC practices incorporate the use of a decision aid (decision support) for patients in shared decision making. One of CPC's core goals is to ensure that resources are used to provide the best possible care. Therefore, we are suggesting that you initially choose shared decision making tools that can be expected to affect overall resource use by targeting conditions in which there is known to be large variation in care with substantial resource consequences. Examples specified for Milestone 7 include conditions in which treatment is clearly preference-sensitive (e.g., low back pain, joint replacement, cataract surgery). Also included are complex chronic conditions (e.g., asthma, COPD, diabetes), for which optimal care includes shared decision making as well as support for self-management.

The Dartmouth Atlas of Health Care provides the following definition of 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 the physician*." The Dartmouth Atlas of Health Care website offers a brief, clear discussion of the role of shared decision making in these conditions.

To encourage the systematic use of decision aids and shared decision making (and the workflow changes this will require), this Milestone requires you to measure how many patients have the condition or treatment decision for which the tool or aid is designed, as well as how many receive the decision aid intervention — a numerator/denominator measure. It will be easier to choose a condition that can be identified in the EHR so that the measure can be captured electronically, but it is not a requirement that you capture the measure electronically. Ideally, the majority of your work will go toward adjusting workflow to accommodate the use of decision aids in shared-decision making, not in developing the tracking and reporting system.

Milestone 7 asks that CPC practices incorporate use of a decision aid to support shared decision making into the workflow of the practice. It is an important element of the Milestone that the use of the decision aid is a part of the practice workflow.

Q: How does shared decision making differ from motivational interviewing?

A: Decision aids are an important tool for shared decision making, providing patients with the information they need to make informed decisions and offering the opportunity to incorporate this knowledge in discussions with their provider. Motivational interviewing is also an important tool for shared decision making, involving techniques for using the patient's own goals and desires to guide the discussion.

7.2 Choosing a priority area

Q: May we use a form and information packet to assess and discuss obstetrical patients' wishes regarding genetic screening (first trimester screens, Materni21, quad screen, cystic fibrosis screening, etc.) to meet the criteria for Milestone 7?

A: Yes. This is a good example of a decision aid to support patients in shared decision making about a preference-sensitive condition or set of tests. The information packet should include documents that one, provide information about the tests, including options, benefits and risks; and two, help interpret options in the context of a patient's values and preferences. Patients should be guided on how to discuss their values and preferences with the health care provider/team.

Q: May we focus on end-of-life issues (e.g., advance directives) to complete the shared decision making Milestone?

A: The purpose of Milestone 7 is to build the workflow and capacity to use decision aids to support shared decision making so that the preference-sensitive care the practice provides is based on informed patient choices. The Milestone focuses on that process, not the results of the decision.

Certain decision aids comprehensively address medical care choices for individuals who are seriously ill. These tools are, by definition, shared decision aids and they outline and explain treatment options without bias while eliciting patient preferences and values.

Advance directives, living wills, or Physician Orders for Life Sustaining Treatment (POLSTs) are documents that memorialize treatment preferences once they have been decided. The purpose of an advance directive/living will is to provide legal documentation of patient wishes. A health care power of attorney designates a surrogate for medical decisions. The POLST (in some states, MOLST) records physician or medical orders that are consistent with patient preferences or values. Some EHRs can capture signed advance directives or POLST forms.

If you wish to focus on improving the patient-centeredness of care for individuals with serious illnesses for Milestone 7, you should select an aid that provides unbiased information to support patient decision-making, make that aid available to appropriate patients, and document its use in the medical record. The advance directive/POLST form could be a part of a care plan that memorializes a patient's informed treatment decisions but is not itself a decision aid.

7.3 Choosing a decision aid

Q: May we create our own shared decision-making tool, and if so, is approval needed?

A: Creating a shared decision-making tool would be quite burdensome and resource-intensive for a practice. An industry exists for creating these tools. The tools are written at a 6th-grade reading level, evaluated to ensure there is no bias regarding treatments, etc. Some of the tools are publicly available and others can be procured by vendors. It is recommended (but not required) that you select one of these options and use the available resources to integrate and measure the tool’s use in the clinical setting. Please select a balanced aid that covers all of the options, alternatives, risks and benefits of a test, condition or treatment. CMS does not have specific standards for decision aids, and CPC is not certifying or approving decision aid tools.

Q: Would a diabetes action plan (specifically the section in which patients choose a self-management goal to add to their daily routine) meet the criteria of a shared decision-making tool? We would offer patient education for each goal patients could choose and would track the total number of action plans distributed (denominator) compared to those completed (numerator). We would complete the action plans in hard copy for patients to take home and document and code them in the EHR.

A: A decision aid to help patients set a self-management goal (e.g., a target for their HgbA1C) would be appropriate. In that case the numerator should be the number of patients who use the decision aid to help them set a goal. The diabetes action plan documents and memorializes the decisions that the patient makes after review of the decision aid and discussion with the clinician. In that case the denominator might be the patients completing a diabetes action plan. The measure tells you how many of the patients who completed a diabetes action plan used a decision aid to help them identify their goals.

Q: Could we use a patient education packet regarding colonoscopies as a decision aid if the packet includes information about the procedure and addresses the risks and benefits?

A: Colon cancer screening is a good example of a preference-sensitive test/condition that can be supported by shared decision making. It is important that the education packet first provide information about all tests and screening options, including risks and benefits for each; and second, help interpret options in the context of the patient’s values and preferences. Patients should be guided on how to discuss their values and preferences with the health care provider/team.

Q: May we offer patients more than one shared decision-making aid to provide more information for a particular condition (e.g., by referring patients to our website to view multiple decision aids available for the condition)?

A: Yes, this meets the intent of Milestone 7.

Q: Is a shared decision-making tool available for the prostate-specific antigen (PSA) test?

A: The American Urological Association website offers an educational pamphlet titled “Is Prostate Cancer Screening Right for You?” The Mayo Clinic also offers a tool at on its website.

Q: Where can we find shared decision-making software?

A: www.healthwise.org offers one of many sources of shared decision-making software. CMS does not endorse any particular source.

Q: Is there a recommended Shared Decision Aid tool or Shared Decision Making tool?

A: CMS does not endorse specific Shared Decision aids or tools. It's important that the decision aid selected: 1) provide information about all tests/screening options, including benefits, and risks for each; and 2) help interpret options in the context of the patient’s values and preferences. Finally, we expect that patients will be guided on how to discuss their preferences and values with the provider or care team.

CMS will request that practices identify the source or producer of the decision aid when completing the reporting on this Milestone on the web application.

7.4 Using the decision aid

Q: Our practice plans to use PSA testing as a decision aid. Does it matter that this decision does not represent our entire population?

A: No. By limiting the use of the decision aid to the appropriate patients, you are meeting the intent of the Milestone.

Q: How many patients are expected to have used the decision aid? Is there a specific percentage goal for the numerator/denominator?

A: A specific percentage goal has not been set. The point of the measure is to help you see whether decision aids are actually being used in your practice and to guide adaptation of workflow to incorporate decision aids.

Q: Is there a recommended amount of time from when a decision aid tool is given and when a patient completes the tool?

A: It is recommended that you have a process in place for closing the loop regarding use of the decision aid. That may be a visit, a phone call or a "My Chart" message. You should have a way of determining whether the patient looked at the decision aid and how the patient wants to proceed. The discussion with the clinician after the patient has reviewed the decision aid is a crucial part of the process.

Q: We would like to choose a condition and pull a numerator and denominator from patients who see a health coach, rather than including every patient who is seen in the practice with this particular condition. Would this meet the Milestone?

A: Yes, this meets the intent of Milestone 7.

Q: Is referring a patient to an educational center for information on treatment and best practices for diabetes considered a shared decision-making aid if the patient's visit summary is reported back to the practice for follow-up?

A: While this is good clinical practice, it is patient education rather than shared decision making. Shared decision making is an approach in which clinicians and patients work together using the best available evidence when faced with the task of making decisions, and in which patients are supported in considering options and their preferences are solicited s to determine the best action.

An example in which shared decision making might be appropriate for a patient with diabetes is in choosing the initial medication regimen. Often, several reasonable options are available for the first step of therapy. Providing patients with a decision aid that helps them consider the relative benefits and risks of each option allows for an informed discussion between patient and provider to arrive at a decision.

7.5 Reporting rate of use

Q: How should we build a report to track use? Custom reports involve expense and may not be routinely available from the EHR vendor.

A: You should start by identifying patients eligible to participate in shared decision making around your chosen priority area(s). CMS suggests finding out if automatic ways are available to produce a report of all patients who are candidates for receiving the decision aid. Then identify the patients who actually received the decision aid. From there, you can produce a measurement report indicating how many of the eligible patients actually received the decision aid. The description should include the method used for identifying eligible patients (the denominator).

Q: Is there a recommended way to monitor patients' use of decision aids outside the practice?

A: The use of the decision aid should be incorporated into the workflow of the patient visit so that patients have the opportunity to use the information they gain in shared decision making with their provider. Your staff may also track patients who participate in shared decision making and request feedback by phone, through patient portals or through other electronic communications, such as patient surveys. No one specific method is recommended.

Q: How should we measure the effect of shared decision making?

A: Start by measuring rates of use this year, including monitoring patients' use of the aids. You may want to include shared decision making in your patient survey and/or advisory council activities.

Milestone 8: Participation in the CPC Learning Collaborative

Intent of Milestone 8

Milestone 8 involves active participation in a learning community to build the knowledge, skills, competence and practice capacity to deliver Comprehensive Primary Care capable of achieving better care, better health outcomes and lower cost of care through improvement in care. By sharing what worked and what did not work, CPC practices accelerated the pace of learning and innovation that remains essential to the success of the CPC initiative.

How Milestone 8 addresses the CPC Change Package

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.
3.2C: Active participation in transformation collaborative.

Work Elements for Milestone 8

1. Attend three all-day Learning Sessions in PY 2013
2. Attend Web-based meetings at least monthly
3. Share materials or resources you use on the Collaboration website
4. Select at least six key measures to guide active testing of change (patient experience, risk status assignment, care coordination, etc.). These should be measures already used by the practices in their work in the other Milestones and in their work with the Clinical Quality Measures.

Documenting the Work in Milestone 8

Practices were asked to participate in the regional learning collaborative and share knowledge, tools and expertise with other practices.

Practices' Approach to Milestone 8

Incorporating CPC Participation into a Single Physician Practice's Workflow

Grand Lake Primary Care, Grove, Oklahoma (solo physician practice)

This practice consists of a physician, an office manager, a lab tech, a receptionist, a medical assistant and a care manager. To participate in the learning collaborative, the staff plans the patient schedule ahead of time to allow all staff members, except the lab technician, to attend the all-day learning sessions. The weekly team meetings are arranged so that the CPC webinar, if scheduled, is one of the agenda items. Because everyone is part of the care team, the entire staff participates in the webinar presentations. The office closes to allow attendance at face-to-face meetings.

During the virtual all-day-learning sessions, the practice was opened to see just a few patients who could not be rescheduled. All staff gathered to share a large computer screen, listen to the presentations and discuss the topic at hand.

The practice staff found one idea presented in a webinar particularly helpful: one practice shared how it attempted to reduce ER visits by extending their office hours. The team looks forward to these concrete examples of the work done by other practices as it helps their team envision how to do the work as well.

Ongoing participation in the learning collaborative is easier when webinars are held at noon, as this is the regularly scheduled CPC weekly team meeting time and that helps the whole team participate. Staff sometimes reviews the recorded sessions during the team meetings.

How a Multi-Site Practice Plans Participation in CPC Events and Uses the Collaboration Website

PriMed Physicians, Beavercreek, Ohio (group practice)

The health system includes 20 medical offices, six of which are in the CPC initiative program. As the practice became more knowledgeable about the program, the resources provided during the webinars and on the Collaboration website became more meaningful.

When notification of the webinar's topic is received, the practice selects staff to attend according to the relevance to each person's job role. Staff attends from their office site's common computer as practical, or alternatively from their individual computers, when group attendance was not practical.

At the beginning of the CPC enrollment, two project leaders found the webinars provided helpful insight into the activities of other CPC practices across regions as well as a deeper understanding of the work needed to accomplish the Milestones. As the project leaders learned more, work was adjusted accordingly.

Staff routinely searches the Collaboration Site for resources pertaining to workflow changes and to view the activities in other regions. For example, the practice looked for information on change management, care coordination, care manager job descriptions and care plan templates. Access to this information helps to refine and translate care management responsibilities into efficient workflows for the staff.

FAQs for Milestone 8

Below are questions practices asked during PY 2013 as they were completing the day-to-day work of CPC. These frequently asked questions are provided here to illustrate various practice approaches to achieving the Milestones and specifics that needed to be addressed as practices implemented innovative tactics.

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

Q: What are the exact requirements are for Milestone 8?

A: There are no reporting requirements for the practices for Milestone 8. Practice participation in the CPC Collaborative is tracked to ensure that the practice is fulfilling this commitment and if there are concerns about your participation, you will be notified.

Milestone 9: Meaningful Use

Intent of Milestone 9

Milestone 9 leverages the Meaningful Use program as a foundation for optimal use of the electronic health record in the care of patients.

Work Elements for Milestone 9

Meeting the requirements of successful attestation to Stage 1 of Meaningful Use in the Medicare and Medicaid EHR Incentives Programs meets the requirements of Milestone 9.

Documenting the Work in Milestone 9

CPC practices demonstrated achievement of Milestone 9 by all "eligible professionals" (EPs) in the practice successfully attesting to Stage 1 Meaningful Use in the Medicare EHR Incentive Program or their state's Medicaid EHR Incentive Program.

How Milestone 9 addresses the CPC Change Package

HIT Functions

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 staff to develop, maintain and improve EHR function.

Practices' Approach to Milestone 9

Meaningful Use Builds Confidence for CPC Work

Grand Lake Primary Care, Grove, Oklahoma (solo physician practice)

This solo physician attested to meaningful use for the first time in 2011. Her path to attestation included watching the EHR training videos and attending the online training sessions. The physician in turn trained the staff to use the software to support consistent workflows to capture the structured data required for reporting.

Having achieved Meaningful Use, the physician recognized how the MU Milestones go hand-in-hand with CPC Milestones, thus increasing her confidence in managing the work required for CPC. The required reporting of Clinical Quality Measures for meaningful use prepared her for capturing the structured data required for CPC Clinical Quality Measures.

Performance reports in the EHR (Soapware) are easily displayed on a dashboard in the EHR, allowing the staff to quickly review and identify how Clinical Quality Measures could be improved through adjustments in workflow or implementing interventions. For example, one intervention was to adjust the exam room to better accommodate foot exams for patients with diabetes.

The practice's physician also collaborates with four providers in the community to share ideas and strategies that apply to Meaningful Use and the CPC work. One suggestion was to share their workflow processes. The charts are posted at the nurse's station, and if changes are needed, the team runs through the current workflow. Changes are then made to the workflow process and the document is reprinted and posted again. The willingness of staff to adopt, adapt and adjust as needed has made this process a smooth one.

As other reporting needs are discovered, the EHR vendor provides onsite training and assistance. The biggest barrier has been the lack of bandwidth with the EHR vendor, and readiness of the software for the required functions beyond Meaningful Use Stage 1. This will necessitate an EHR change in early 2014.

How a Multi-Site Practice Achieved Meaningful Use and How It Influences Its CPC Work

PriMed Physicians, Beavercreek, Ohio (group)
This is a multi-office, independent medical group with 20 medical offices, six of which are in the CPC initiative. The CPC offices have successfully attested to Meaningful Use in early 2012.

PriMed's first step toward achieving MU was upgrading the EHR to a MU-certified version. Our staff received training on workflows required to achieve MU. By running monthly quality reports and sharing those reports with staff during team meetings, we could gauge the effectiveness of the workflow. One-on-one training was given to any staff who struggled with the EHR concepts.

Practice staff found the EHR vendor's training to be too complex, difficult to tie to the MU objectives, and not tailored to the staff person's role and daily work (physician versus nurse). Instead, the practice's project leaders trained the staff by translating MU objectives into how those affected workflow and documentation. The practice workflows sometimes had to change to meet the MU objectives.

Our EHR vendor had misinterpreted the reporting requirements, which affected accuracy. For example, PriMed's practice leaders have assessed that the influenza numbers are actually much higher than what the EHR reports shows due to inadequate mapping of all the diagnosis codes to the report rules. Achieving MU helped our staff to better understand the Clinical Quality Measures for CPC, which helped to identify work for the vendor to do to improve the reports for CPC.

Clinical quality measure reports help guide the workflow and adjustments of that work over time. Routinely, we review reports for trends, impact of tests of change, and to determine where to focus improvement efforts. We discuss all changes or suggestions for change at all-office manager meetings. A physician champion from every office (not just the CPC offices) attends the workflow change meetings where work processes are reviewed to detect where changes will cause the need for adjustments. The practice also prioritizes the work staff does to support care management/care coordination, such as training and coaching or educating patients. Several times throughout the year the staff meets to discuss process changes and how they affect each person's role. The physicians weigh-in on the quality initiatives. To help everyone be aware of the work, workflows are posted on the office walls for all staff to see.

Tools and Resources for Milestone 9

Click here to access the complete list of resources for all Milestones.

The CPC program shared several resources including the following EHR Incentive Programs website links to help EPs properly meet meaningful use and attest, including:

- A **Registration & Attestation page** that included links to additional resources.
- The **Meaningful Use Attestation Calculator** allowed EPs and eligible hospitals to determine if they have met the Stage 1 meaningful use guidelines before they attest in the system.

- The **Attestation User Guide for Medicare Eligible Professionals** provided step-by-step guidance for EPs participating in the Medicare EHR Incentive Program on navigating the attestation system.
- The **Attestation Worksheet for Eligible Professionals** allowed users to enter their meaningful use measure values, creating a quick reference tool to use while attesting.

Practices were encouraged to visit the EHR Incentive Programs website for the latest news and updates on the EHR Incentive Programs.

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.

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.

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

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.

FAQs for Milestone 9

Below are questions practices asked during PY 2013 as they were completing the day-to-day work of CPC. These frequently asked questions are provided here to illustrate various practice approaches to achieving the Milestones and specifics that needed to be addressed as practices implemented innovative tactics.

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

Q: What are the date parameters for Milestone 9? Will CMS be using the EP NPI list from project start or from a certain point in 2013?

How will practices be reporting Milestone 9? Will it be automatic feed from ONC to CMS (like the list sent out in June) or will practices need to upload EP attestation IDs?

A: For CPC practices, meaningful use (MU) attestation will not be an automatic feed from ONC to CMS.

Eligible professional has three definitions:

1. MU definition for Medicare EP,
2. MU definition for Medicaid EP, and
3. PQRS definition for EP – Medicare program ONLY

For Medicare and Medicaid EP Definitions and guidance, visit the CMS website, specifically the Regulations and Guidance/Legislation for EHR incentive programs section.

For PQRS EP Guidance, visit the CMS website, and select the “Medicare” tab, and scroll to the Quality Initiatives/Patient Assessment instruments. A link to PQRS is listed there.

EPs will have until April 4, 2014, to provide evidence of successful meaningful use attestation in CPC Milestone 9. EPs that join the CPC practice **after** October 1, 2013, will not need to meet this requirement for 2013. This means that CPC EPs would have to be active in the practice before October 3 to have 90 days of data to report on for 2013. CPC Practices need not worry about EPs who have left their practice.

Note that there are three definitions of Eligible Professional: one, MU definition for Medicare EP; two, MU definition for Medicaid EP; and three, PQRS definition for EP – Medicare program ONLY.

Master List of Resources

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.

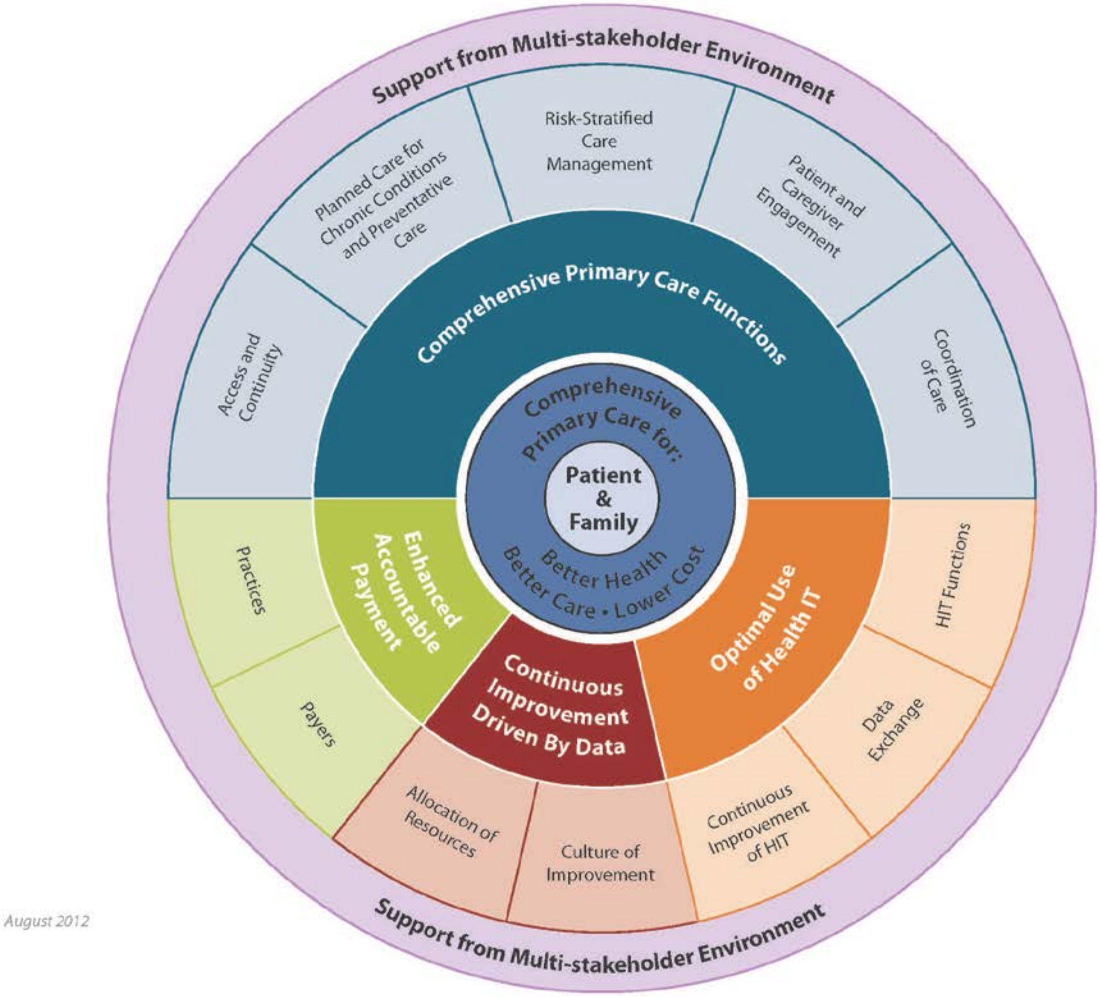


Figure 1. The CPC Logic Model

Primary Driver – 1.0 Comprehensive Primary Care Functions

Table 1: 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 2: 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.

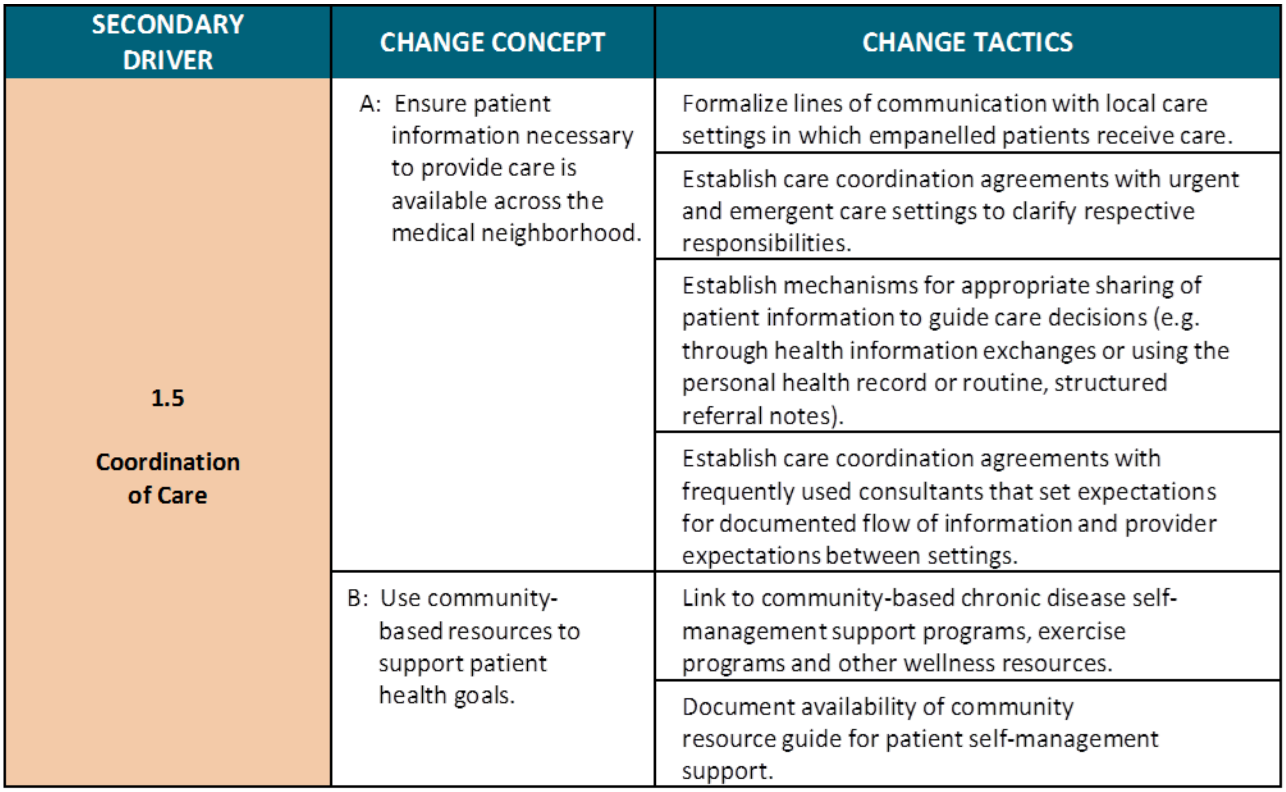
Table 3: Secondary Driver 1.3 Risk-Stratified Care Management

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 4: 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 5: 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 6: 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 7: 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 8: 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.

Tools and Resources Relevant to CPC Functions and Milestones

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

Resources for Milestone 1

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.

Tools

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.

Resources for Milestone 2

Care Management Tools

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.

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

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.

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.

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.

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
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.

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.

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 their 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, ARK/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.

Resources for Milestone 3

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.

Resources for Milestone 4

Survey and PFAC Tools

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.

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.

Resources for Milestone 5

Tools

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

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.

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.

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. Includes the documentation process and lists responsibilities by role.

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.

Resources for Milestone 7

Tools

Integrating Patient Decision Aids into Primary Care Practice (71-page PDF)
Oregon Rural Practice-Based Research Network produced this Shared Decision Making tool kit, 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 tool kits 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 patient 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.

Resources for Milestone 9

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.

Spotlight Articles

Articles in this section:

SAMA HealthCare Services, De Queen, Arkansas, Nov. 15, 2013 and Dec. 6, 2013

Primary Care Partners, Grand Junction, Colorado, Dec. 20, 2013

This week we go to El Dorado, Ark., to visit SAMA Healthcare Services, an independent four-physician family practice located in rural southeast Arkansas. Employing about 45 people, the practice has on-site lab and radiology, offers bone density testing, and does its own billing. Its EMR is Allscripts. The clinic's four physicians care for approximately 19,000 patients, many who travel from the surrounding rural communities for health care.

"Sometimes Arkansas feels like it's five years behind everyone else," said Gary Bevill, MD, a physician partner in SAMA Healthcare Services. "But not us. Our partnership has always pushed the envelope, and we see this as the leading edge of where medicine is going."

Keeping their eye on the leading edge is what attracted physicians **Gary Bevill, Matthew Callaway, Eric Hatley** and **James Sheppard** for their practice to apply for the CPC initiative. Already robust users of their Allscripts system, the team see the CPC opportunity as an opening for accelerating their progress toward higher quality care in a proactive, coordinated patient-centered environment.

"A lot of the things we're doing now, are things we wanted to do in the past," said **Pete Atkinson**, SAMA's practice administrator. "We needed the front-end investment of start-up money to develop our teams and our processes."

Leveraging the CPC dollars helped Pete and the physicians re-configure the clinic into four care teams, each led by a physician and supported by a nurse practitioner, three additional nurses and a care coordinator. The funding allowed them to hire the needed nurse practitioners, including one who is a certified diabetes educator and another with a pediatrics specialty certification.

Early in the founding of the clinic, all patients were assigned to a physician, making 100% empanelment easy. Going forward, now they have a dedicated care team tracking and monitoring their care.

SAMA staff wears team shirts and colors to help patients see the continuity and collaboration in their care.

Risk Stratification and Care Management

Physicians trained nurses on using the risk stratification feature in Allscripts as well as the AAFP six-level risk stratification tool. Nurses mark records and the physician confirms the stratification during the patient encounter. As nurses are reviewing records for the next day's appointments, not only are they able to risk-stratify the patients, they are also able to ensure preventive care and screenings are up to date.

“We also turned on all the Allscripts metrics including the clinical decision support,” continued Dr. Bevill. “We are being very proactive, and now I’m seeing patients with everything up to date and current. The first time it happened, I nearly dropped the iPad.”

798 likes · 266 talking about this · 909 were here

Family Medicine Practice
600 South Timberlane Drive, El Dorado, Arkansas 71730
(870) 862-2400
Today 8:00 am - 6:00 pm

About - Suggest an Edit

SAMA Healthcare Services shared South Arkansas Eye Clinic's photo.

Invite Your Friends to Like This Page

SAMA’s Facebook page is one outlet for sharing information about CPC activities, including announcing practice surveys and explaining the new care team model.

Even from Pete’s practice manager perspective, he’s seeing the difference the coordination and care management is making.

“We have found early stages of cancer in our patients through this process,” he says. “Sure, we’re kind of pestering our patients to get that preventive care done, but it’s paying off. The big picture is that we’re saving the system money and improving lives by finding a stage 1 cancer rather than a stage 3. We may have saved the overall system what they have paid us to participate in CPC.”

Demonstrating a New Approach

Informing patients about the changes at SAMA have taken many forms, ranging from each care team adopting its own color to refreshing the clinic’s logo to show how the four teams underscore SAMA’s brand promise of quality and continuity. Each exam room is tagged with a team color.

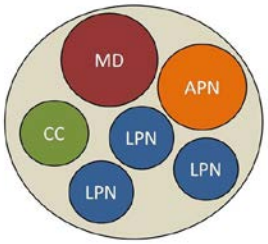
SAMA also keeps its Facebook page filled with clinic updates, such as an illustration of its care team model and links to media coverage about its CPC engagement.

“We are proud of our business,” Dr. Bevill said. “But it’s always really and truly been about the patients. We wanted to do this our way, doing what’s best for our patients and our community. A lot of people don’t like change, but our staff has seen this is change for the better.

“They all see we’re providing better care.”

Next Spotlight: The How and Why of SAMA’s Success

Using Social Media to Educate and to Inform



“I was asked this weekend about Care Teams so I thought I'd take a minute to explain what we are doing. This picture shows the basic concept. In the past each provider acted independently. One complaint we heard was that patients wanted to see “their doctor.” From the physician's standpoint they want to see their patients as continuity of care is very important. So the team is designed to correct this issue as well as address the need for more attention to preventive services. Each team will consist of a doctor, a nurse practitioner, a care coordinator, and three nurses. Once in place, a patient will be able to be seen by their team 99% of the time (doctors do take vacations) during normal business hours. When patients call; they will be speaking with the members of their team who will know them personally and will be better able to address their needs. After hours and on weekends will still be covered by an APN or physician on call. The results will be more same-day visits with each provider/team and increased quality of care.” – *SAMA Practice Administrator Pete Atkinson’s Facebook post about the new team approach*

Practice Spotlight

December 6, 2013

SAMA
HEALTHCARE

In this installment of the Practice Spotlight*, we take a deeper look at how SAMA Healthcare Services in El Dorado, Ark., has blended risk stratification and care management to improve its already strong preventive care services. As described in the Nov. 15 article, the practice created four care teams, each headed by a physician and supported with a nurse practitioner, three additional nurses and a care coordinator. This team model not only fosters better coordination, but as you will read below, it creates a culture of where all staff take ownership of patient care, resulting in measurably better care.*

Risk Stratification Levels (merging of AAFP and Site Risk)

AAFP (Level 5 & 6) / Site Risk = HIGH

- ✓ Diabetes Mellitus, uncontrolled
- ✓ Hypertension, uncontrolled
- ✓ COPD
- ✓ CHF
- ✓ History of CVA
- ✓ CAD/Vascular Disease
- ✓ Obesity, morbid (BMI > 35)
- ✓ Renal Disease
- ✓ Cancer (active disease and/or on hospice)
- ✓ Hospitalization in the last 12 months

AAFP (Level 3 & 4) / Site Risk = MEDIUM

- ✓ Diabetes Mellitus, controlled
- ✓ Hypertension, controlled
- ✓ Hypercholesterolemia, controlled
- ✓ Obesity (BMI > 30 but <35)
- ✓ Hypothyroidism, stable
- ✓ Asthma
- ✓ Cancer (remission)

AAFP (Level 1 & 2) / Site Risk = LOW

- ✓ No chronic medical conditions, no medications

Change is a constant at SAMA Healthcare Services. While the most significant event was adopting an electronic health record nearly 12 years ago, continual re-evaluation among the practice's partner physicians has kept them "out on that edge," as **Gary Bevill, MD**, put it.

How SAMA Risk Stratifies

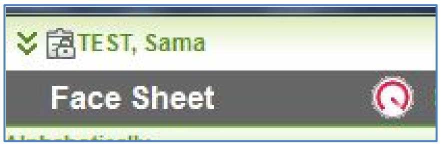
Through its work with CPC, SAMA formed care management and care teams, who drive proactive preventive care for the practice's approximately 19,000 patients. **Risk stratification** is among the core functions of the new care team.

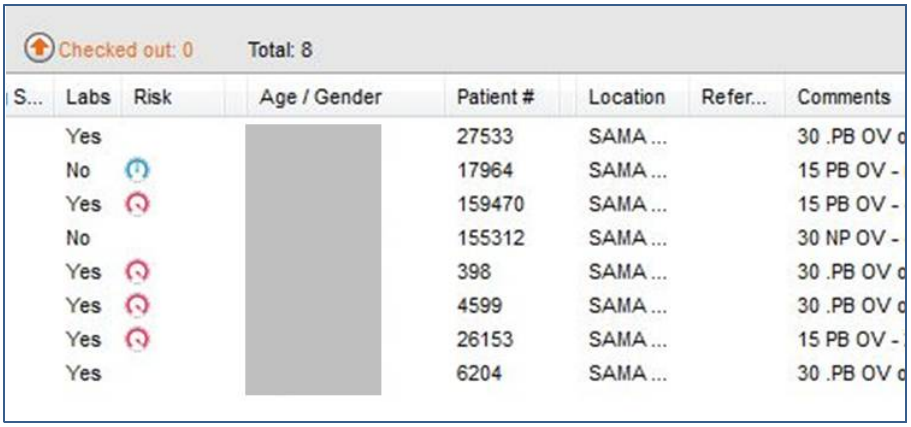
Nancy New, LPN, clinical informatics coordinator, described the process, "Our doctors got together and agreed on a set of diagnoses as risk factors and what level that factor would be. Then, they trained their teams by going over those lists and talking through their questions. Now when patients make appointments, the team care coordinator reviews the medical record before the appointment."

SAMA turned on Allscripts' Clinical Decision Support features, which alert the care team to missing screenings or lab work and checks health maintenance measures. Occasionally gaps are rectified when results are re-entered in the discrete fields, but when screenings are needed, the coordinator asks the patient to visit SAMA's in-house lab before the appointment.

Using the recent Allscripts stratification product release and combined with the AAFP Risk Stratification Tool, the coordinator flags the patient record prior to the appointment. The coordinator assigns a high risk (red) flag if the patient has complications of a major diagnosis (diabetes, HTN, COPD, CHF, CVD/stroke) or more than two diagnoses in that group. A medium risk (blue) flag is assigned if disease management is in control. Low risk (green) is assigned to patients with no chronic medical conditions or medications.

Right: *Note the icons for patients in the appointment view. Blue is medium risk; red is high risk. Patients under 18 are not stratified.* ***Below:*** *Face sheets are also tagged with risk levels.*



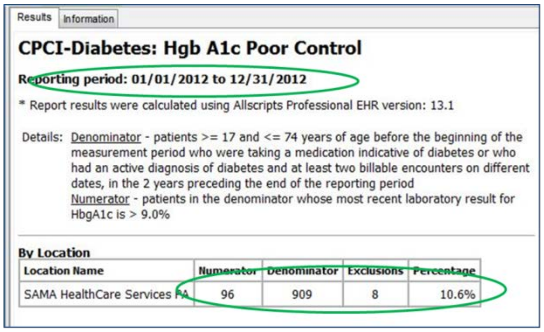


Checked out: 0 Total: 8

S...	Labs	Risk	Age / Gender	Patient #	Location	Refer...	Comments
	Yes		[redacted]	27533	SAMA ...		30 .PB OV
	No	🔵	[redacted]	17964	SAMA ...		15 PB OV -
	Yes	🔴	[redacted]	159470	SAMA ...		15 PB OV -
	No		[redacted]	155312	SAMA ...		30 NP OV -
	Yes	🔴	[redacted]	398	SAMA ...		30 .PB OV
	Yes	🔴	[redacted]	4599	SAMA ...		30 .PB OV
	Yes	🔴	[redacted]	26153	SAMA ...		15 PB OV -
	Yes		[redacted]	6204	SAMA ...		30 .PB OV

During the patient encounter, the physician further reviews the assessment and confirms the appropriate flag in the medical record.

"We were doing some risk assessment earlier, and making that happen with some work-arounds in the EHR," continued Dr. Bevill. "When the new product release came out, we jumped on that."



Results | Information

CPCI-Diabetes: Hgb A1c Poor Control

Reporting period: 01/01/2012 to 12/31/2012

* Report results were calculated using Allscripts Professional EHR version: 13.1

Details: Denominator - patients >= 17 and <= 74 years of age before the beginning of the measurement period who were taking a medication indicative of diabetes or who had an active diagnosis of diabetes and at least two billable encounters on different dates, in the 2 years preceding the end of the reporting period
Numerator - patients in the denominator whose most recent laboratory result for HbgA1c is > 9.0%

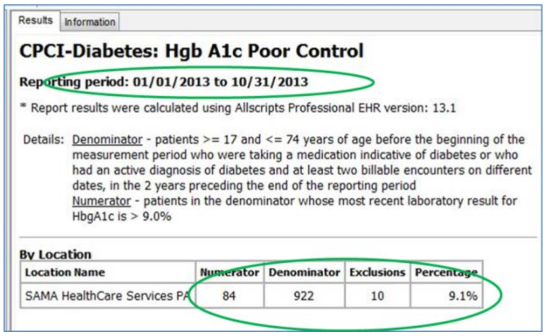
By Location

Location Name	Numerator	Denominator	Exclusions	Percentage
SAMA HealthCare Services PA	96	909	8	10.6%

Before enrolling in CPC, SAMA physicians decided to focus on timely A1c testing for their patients with diabetes.

"First, we educated patients to ask for the test every quarter. We told them why it's important, and we asked them to work with us," said Dr. Bevill.

Over time, rates of A1c testing increased. When the practice took its first measurement for CPC, the results were pretty good for their demographics.



Results | Information

CPCI-Diabetes: Hgb A1c Poor Control

Reporting period: 01/01/2013 to 10/31/2013

* Report results were calculated using Allscripts Professional EHR version: 13.1

Details: Denominator - patients >= 17 and <= 74 years of age before the beginning of the measurement period who were taking a medication indicative of diabetes or who had an active diagnosis of diabetes and at least two billable encounters on different dates, in the 2 years preceding the end of the reporting period
Numerator - patients in the denominator whose most recent laboratory result for HbgA1c is > 9.0%

By Location

Location Name	Numerator	Denominator	Exclusions	Percentage
SAMA HealthCare Services PA	84	922	10	9.1%

However, increased care coordination made a significant difference. Care coordinators called patients due for an A1c. A nurse practitioner who is also a Certified Diabetes Educator increased patient education efforts and coaching tactics. Physicians wrote "prescriptions" to a local gym to encourage exercise. Patients with diabetes learned to ask about the A1c. And the numbers started to move. ***The percent of patients with diabetes considered poorly controlled has dropped 1.5 percentage points from 2012 to 2013.***

"If you look at our A1c rates to date for 2013, we've tested more patients than in all of 2012 and our numbers are dropping," pointed out Dr. Bevill. "My patients are way better off with this new system." *(See screenshots.)*

Dr. Bevill reflected on this progress. "You know, I found one of our old (EHR) manuals from 2002 the other day. It was nowhere near to what we're doing today. At first running those reports was tedious, but as it evolved, it got easier. If we had been late adopters, these changes would have been more challenging."

He continued, "We as doctors often think our way is the only way. You really have to be flexible in your thinking and use what's out there to get you where you need to go. My partners and I are willing to try things. It's been a fun run."

Primary Care Partners, P.C.
Your Partner in Health

Drive west from Denver on I-70, and just before you head into Utah, you will arrive at Grand Junction, Colorado. Abutting the scenic Colorado National Monument, Grand Junction is where ***Primary Care Partners*** *operates a multi-site primary care practice serving 65,000 active patients through three family medicine offices, a pediatrics office, an after-hours facility and a satellite pediatrics office.Two sites are CPC practices. Primary Care Partners employs 54 physicians and 13 mid-level practitioners.*

It’s a moment most physicians dread.

“The appointment is nearly over, and the doctor is wrapping up the visit, and that’s when the patient says, ‘Oh, by the way, you should know…’ and she bursts into tears.”

Managing Associate **Carol Schlageck** is describing an encounter that happens every day in a family practice.

“That moment is when you really find out what’s going on, and why the patient is in crisis. The question for most practices is, ‘*Do you have the resources right there in the clinic to help that patient?*’” she asked.

“Today, we do,” was Carol’s confident reply.

CPC at Primary Care Partners

While Primary Care Partners has long benefitted from physician leadership who emphasized quality improvement as a daily activity, engagement with CPC has taken the practice to a new level of service.

“CPC has offered us a wealth of information to help facilitate systems change,” Carol said. “We knew the opportunities were out there, but the funding helped us test and implement strategies we had been eyeing for years.”

She continued, “The Initiative gave us the resources to build the practice we envisioned. Who would argue with that? Who wouldn’t want the medication reconciliation support? Additional tools to help patients with their social and psychological needs?”

From the top: The Primary Care Partners office in Grand Junction offers a range of services, including diabetes education, in-house radiology and an in-house diagnostic lab.

Primary Care Partners has leveraged involvement in CPC to fill pressing needs in their daily workflow. To manage care, they added six staff who are a mix of RNs and social workers, which Carol said “gives us the best of both professions” in working with patients’ care management or a situational crisis requiring resource coordination.

Prior to enrolling in CPC, the practice used a program within the EHR to highlight patient status based on various NCQA quality measures and standards. Through CPC, they developed a formal process through tools and provider identification to evaluate all patients for risk. At this time, they actively manage care for about 750 to 1,000 patients.

During weekly and bi-weekly care coordination meetings the entire team reviews patients' status. Providers report that these meetings have changed how they have addressed after-hours situations for some patients. One said, "Because we talked about [this patient], I was able to handle his call during the night differently and saw [the patient] first thing the next morning. If I didn't know the history, I would have referred [the patient] to the ER."

The new risk stratification process has helped prevent at least seven hospital admissions in three months, as well as decrease ED utilization for a "frequent flier," who had been in the ED 41 times in the previous year. Working closely with a care manager, the patient went seven weeks without an ED visit.

"Through CPC we now have behavioral health clinicians embedded in our clinics," Carol said. "Previously we had a relationship with a behavioral health office in one of our facilities, basically 25 feet from our reception desk. The close proximity let us to do a 'warm hand-off' for patients in crisis. CPC allowed us to subcontract with several behavioral health clinicians who assist with all sorts of behavioral and life issues, such as grief counseling, marriage discord, depression, anxiety, stress, drug use/abuse, parenting issues and eating disorders. The behavioral health clinician can meet the patient with the provider or see the patient independently."

What Happens at the Top Sets the Tone for Embracing Change

When Primary Care Partners enrolled in CPC, every employee at every level became a participant in the effort. **Executive Director Michael Pramenko, MD**, and Carol made presentations to all staff – including housekeeping and facilities – to help them understand the project and how they could contribute.

Michael Pramenko, MD, Primary Care Partners Executive Director

"We talked to everyone. We wanted to energize them, and to fully explain that we're not asking you to work *harder*, but to work *smarter*," Carol said. "They were terrific. They saw the opportunity for improvement and embraced the new systems and staff."

Several processes feed the momentum for change, including a Quality Improvement Series (QIS) Task Force that meets every two weeks with physician leadership and representation from both CPC practices as well as the IT department. The QIS sets policies and helps implement change. Additionally, regular Care Team meetings involve physicians, mid-levels, care managers, behavioral health clinicians and even the office managers. Staff who manage care and coordinate resources meet biweekly for education sessions. Community organizations often present at these meetings to discuss resources and opportunities.

A clinical quality improvement committee meets every two weeks to review CPC progress. Although only two practices are CPC sites, all clinical areas at Primary Care Partners "sit at the table" and are shadowing the work in their own settings. Carol reports that the conversations are lively and highly interactive. Physicians' engagement and interest has prompted an upcoming four-hour retreat for a deep dive session.

The Unexpected Benefits of the CPC Community

"We feel we've been on the cutting edge of practice transformation for a long time," said Carol, pointing to Primary Care Partner's engagement with multiple quality improvement and innovation projects, including serving as a "beta" site for the Informed Medical Decision Foundation's shared decision-making project.

"The camaraderie we feel in the medical community is remarkable. It's exciting to sit with your peers and share the same passion and vision with others who think like we do," she said. "We are part of that larger group and we draw strength from the community. You can see the cohesive effort happening."