Change Concept

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

A. Use a personalized plan of care for patients at high risk for adverse health outcome or harm.
B. Proactively manage chronic and preventive care for empanelled patients.
C. Manage medications to maximize efficiency, effectiveness and safety.
D. Use team-based care to meet patient needs efficiently.
E. Offer integrated behavioral health services to support patients with behavioral health needs, dementia and poorly controlled chronic conditions.

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 Across the Medical Neighborhood

Comprehensive Primary Care for Patient & Family: Better Health, Better Care, Lower Cost

October 2014
Risk stratified care management

Change Concept

A. Assign and adjust risk status to each patient.
B. Use care management pathways appropriate to the risk status of the patient.
C. Manage care across transitions.
Change Concept

A. Integrate culturally competent self-management support into usual care across conditions and provide condition-specific support for self-management of common conditions.
B. Shared decision making.
C. Engage patients and families to guide improvement in the system of care.
Coordination of care across the medical neighborhood

Change Concept
A. Establish standard operations to manage transitions of care.
B. Establish effective care coordination and active referral management.
C. Ensure that there is bilateral exchange of necessary patient information to guide patient care.
D. Develop pathways to neighborhood/community-based resources to support patient health goals.
E. Manage referral networks to meet behavioral health needs not available in the practice.
**Change Concept**

A. Use budgeting and accounting processes effectively to transform care processes and build capability to deliver comprehensive primary care.

B. Align practice productivity metrics and compensation strategies with comprehensive primary care.
Change Concept

A. Build the analytic capability required to manage total cost of care for the practice population.
Culture of Improvement

Continuous Improvement Driven by Data

Change Concept

A. Adopt a formal model for Quality Improvement and create a culture in which all staff actively participates in improvement activities.
B. Ensure full engagement of clinical and administrative leadership in practice improvement.
C. Active participation in shared learning.
Change Concept

A. Measure and improve quality at the practice and panel level.
Continuous improvement of HIT

Change Concept
A. Align with the Meaningful Use (MU) program to improve EHR function and capability.
B. Develop practice capacity for optimal use of EHR.
A. Enable the exchange of patient information to support care.
A. Develop the capability for practice- and panel-level quality measurement and reporting from the EHR.
Change Concept

A. Use population-based payment to purchase comprehensive primary care services.
B. Provide actionable and timely cost and utilization data to practices.
C. Reward practice actions to reduce total cost of care through shared savings or other mechanism.
D. Align quality measures.
A. Engage stakeholders with an interest in better care, better health outcomes and lower overall cost of care in support of CPC practices.

B. Support processes that integrate care across the Medical Neighborhood.