

CPC+ Practice Care Delivery Requirements

The CPC+ care delivery requirements are intended to provide a framework for practices to deepen their capabilities throughout the five-year model. These incremental requirements will guide practices through the comprehensive primary care functions as markers for regular, measureable progress to the CPC+ model aims. Track 2 requirements are inclusive of and build upon Track 1, as the framework for delivering better care, smarter spending, and healthier people in CPC+ is the same across both tracks. Track 1 practices that participated in CPC are expected to continue their work of practice change in CPC+ in PY2017. Track 2 includes additional requirements that will aid practices to increase the depth, breadth, and scope of care offered, with particular focus on their patients with complex needs.

The care delivery requirements in each of the Functions below will evolve and deepen over the term of the model. As practices become familiar with the initial stages of the work and gain expertise, they will be ready to refine their work and will see opportunities to continue to improve the care of and outcomes for their own population of patients.

Practices will report their progress regularly through a secure web portal that will provide both the practices and CMS insight into practice capabilities. CMS will support practices in their work through the requirements with robust learning communities at the regional and national level, and with data feedback for practices to use in care coordination, quality assessment, and improvement activities.

Comprehensive Primary Care Functions

FUNCTION 1: Access and Continuity

Effective primary care is built on a trusting, continuous relationship between patients, their caregivers, and the team of professionals who provide care for them. Expanding access to this primary care team is vital. Whether through expanded hours or developing alternatives to traditional office visits, ensuring that patients have timely access to engage the team will enhance that relationship and increase the likelihood that the patient will get the right care at the right time, potentially avoiding costly urgent and emergent care.

FUNCTION 2: Care Management

Care management for high-risk, high-need patients is a hallmark of comprehensive primary care. Practices will identify those patients in two ways: (1) systematically risk stratify their empanelled population to identify the high risk patients most likely to benefit from targeted, proactive, relationship-based (longitudinal) care management; and (2) identify patients based on event triggers (e.g., transition of care setting; new diagnosis of major illness) for episodic (short-term) care management regardless of risk status. Practices will provide both longitudinal care and episodic care management, targeting the care management to best improve outcomes for these identified patients. Practices will guide their care management efforts by analyzing internal monitoring and payer data, and by using care plans focused on goals and strategies that are congruent with patient choices and values.

FUNCTION 3: Comprehensiveness and Coordination

Comprehensiveness in the primary care setting refers to the aim of practices meeting the majority of its patient population's medical, behavioral, and health-related social needs in pursuit of each patient's health goals. Comprehensiveness adds both breadth and depth to the delivery of primary care services, builds on the element of relationship that is at the heart of effective primary care, and is associated with lower overall utilization and costs, less fragmented care, and better health outcomes.

Practices participating in CPC+ will increase the comprehensiveness of their care based on the needs of their practice population. Strategies to achieve comprehensiveness involve the use of analytics to identify needs at a population level and prioritize strategies for meeting key needs. For some aspects of care, primary care practices can best achieve comprehensiveness by ensuring patients receive offered services within the practice (rather than elsewhere) and also by adding additional services within the practice that might have previously required a referral. Other care and services are best obtained outside of the primary care practice and this should be facilitated through closed-loop referrals and/or co-management with specialists and linkages with community and social services.

Practices participating in CPC+ will act as the hub of care for their patients, playing a central role in helping patients and caregivers navigate and coordinate care. Practices will address opportunities to improve transitions of care, focusing on hospital and ED discharges, as well as post-acute care facility usage, and interactions with specialists. Moreover, this work involves building the capability and network of services both within the medical neighborhood, and the community, to improve patient care. Practices will work to understand where their patients receive care and organize their practice to deliver or coordinate that care in the way that achieves the best outcomes.

FUNCTION 4: Patient and Caregiver Engagement

Optimal care and health outcomes require patient and caregiver engagement in the management of their own care and in the design and improvement of care delivery. Practices will organize a Patient and Family Advisory Council (PFAC) to help them understand the perspective of patients and caregivers on the organization and delivery of care, as well as its ongoing transformation through CPC+. Practices will use the recommendations from the PFAC to help them improve their care and ensure its continued patient-centeredness.

FUNCTION 5: Planned Care and Population Health

Participating practices will organize their care to meet the needs of the entire population of patients they serve. Using team-based care, practices will proactively offer timely and appropriate preventive care, and consistent evidence-based management of chronic conditions. Practices will improve population health through use of evidence-based protocols in team-based care and identification of care gaps at the population level, as well as measure and act on the quality of care at both the practice and panel level.

2017 Practice Care Delivery Requirements, by Track

The care delivery requirements are for the first year of CPC+. Requirements will evolve and deepen over the five-year model.

Track 1: 13 requirements

Track 1, CPC Practices (2012-2016): 17 requirements

Track 2: 24 requirements

-	Track 1	Track 1, CPC Practices	Track 2
<p style="text-align: center;">1 Access and Continuity</p>	<p>1.1 Achieve and maintain at least 95% empanelment to practitioner and/or care teams.</p> <p>1.2 Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR.</p> <p>1.3 Organize care by practice-identified teams responsible for a specific, identifiable panel of patients to optimize continuity.</p>	<p>Track 1 Requirements 1.1-1.3</p>	<p>Track 1 Requirements 1.1-1.3 +</p> <p>1.4 Regularly offer at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population, such as e-visits, phone visits, group visits, home visits, alternate location visits (e.g., senior centers and assisted living centers), and/or expanded hours in early mornings, evenings, and weekends.</p>

-	Track 1	Track 1, CPC Practices	Track 2
<p style="text-align: center;">2</p> <p>Care Management</p>	<p>2.1 Risk-stratify all empanelled patients.</p> <p>2.2 Provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, based on a defined risk stratification process and who are likely to benefit from intensive care management.</p> <p>2.3 Provide short-term (episodic) care management along with medication reconciliation to a high and increasing percentage of empanelled patients who have an ED visit or hospital admission/discharge/transfer and who are likely to benefit from care management.</p> <p>2.4 Ensure patients with ED visits receive a follow up interaction within one week of discharge.</p> <p>2.5 Contact at least 75% of patients who were hospitalized in target hospital(s), within 2 business days.</p>	<p>Track 1 Requirements 2.1-2.5</p>	<p>2.1 Use a two-step risk stratification process for all empanelled patients:</p> <p><i>Step 1</i> - based on defined diagnoses, claims, or another algorithm (i.e., not care team intuition);</p> <p><i>Step 2</i> - adds the care team's perception of risk to adjust the risk-stratification of patients, as needed.</p> <p>Track 1 Requirements 2.2-2.5</p> <p>2.6 Use a plan of care centered on patient's actions and support needs in management of chronic conditions for patients receiving longitudinal care management.</p>

-	Track 1	Track 1, CPC Practices	Track 2
<p style="text-align: center;">3</p> <p style="text-align: center;">Comprehensiveness and Coordination</p>	<p>3.1 Systematically identify high-volume and/or high-cost specialists serving the patient population using CMS/other payer’s data.</p> <p>3.2 Identify hospitals and EDs responsible for the majority of patients’ hospitalizations and ED visits, and assess and improve timeliness of notification and information transfer using CMS/other payer’s data.</p>	<p style="text-align: center;">Track 1 Requirement 3.1-3.2 +</p> <p>3.3 Maintain or enact collaborative care agreements with at least two groups of specialists identified based on analysis of CMS/other payer reports.</p> <p>3.4 Choose and implement at least one option from a menu of options for integrating behavioral health into care.</p>	<p style="text-align: center;">Track 1 Requirement 3.1-3.2+</p> <p>3.3 Enact collaborative care agreements with at least two groups of specialists identified based on analysis of CMS/other payer reports.</p> <p>3.4 Choose and implement at least one option from a menu of options for integrating behavioral health into care.</p> <p>3.5 Systematically assess patients’ psychosocial needs using evidence-based tools.</p> <p>3.6 Conduct an inventory of resources and supports to meet patients’ psychosocial needs.</p> <p>3.7 Characterize important needs of sub-populations of high-risk patients and identify a practice capability to develop that will meet those needs, and can be tracked over time.</p>
<p style="text-align: center;">4</p> <p style="text-align: center;">Patient and Caregiver Engagement</p>	<p>4.1 Convene a PFAC at least once in PY2017, and integrate recommendations into care, as appropriate.</p> <p>4.2 Assess practice capability and plan for support of patients’ self-management.</p>	<p>4.1 Convene a PFAC in at least two quarters in PY2017 and integrate recommendations into care, as appropriate.</p> <p>4.2 Implement self-management support for at least 3 high risk conditions.</p>	<p>4.1 Convene a PFAC in at least two quarters in PY2017 and integrate recommendations into care, as appropriate.</p> <p>4.2 Implement self-management support for at least 3 high risk conditions.</p>

-	Track 1	Track 1, CPC Practices	Track 2
<p style="text-align: center;">5</p> <p>Planned Care and Population Health</p>	<p>5.1 Use feedback reports provided by CMS/other payers at least quarterly on at least 2 utilization measures at the practice-level and practice data on at least 3 electronic clinical quality measures (derived from the EHR) at both practice- and panel-level to inform strategies to improve population health management.</p>	<p>Track 1 Requirements 5.1</p>	<p>Track 1 Requirements 5.1 +</p> <p>5.2 Conduct care team meetings at least weekly to review practice- and panel-level data from payers and internal monitoring and use this data to guide testing of tactics to improve care and achieve practice goals in CPC+.</p>