
# CPC+ CHANGE PACKAGE

January 2017

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# CPC+ DRIVER DIAGRAM

The CPC+ change package is composed of **key drivers, change concepts,** and **change tactics** to guide participating practices through care delivery redesign. While many of the change concepts and tactics are optional, they can all contribute to the model's overall aims of better care, smarter spending, and healthier people. The change concepts and tactics provide strategic ideas for your practice's consideration and application to your specific patient populations, needs, and resources.

In CPC+, your practice is encouraged to redesign the care you provide to your entire patient population based on the **Driver Diagram** (Figure 1), and on lessons learned from the CPC Classic initiative. A driver is a key factor that leads your practice to deliver comprehensive primary care and achieve the CPC+ goals. In the Driver Diagram, the care delivery drivers of the **Comprehensive Primary Care Functions** (in blue) are supported by three foundational drivers: **Use of Enhanced, Accountable Payment** (in green); **Optimal Use of Health IT** (in orange); and **Continuous Improvement Driven by Data** (in red). This entire primary care practice model is supported through **Aligned Payment Reform** (in purple), in which commercial and state payers will partner with CMS in providing a risk-adjusted care management fee (CMF), a performance-based incentive payment (PBIP), and, for practices in Track 2, additional flexibility by shifting a portion of your fee-for-service payment to an up-front comprehensive primary care payment. Change concepts and tactics listed under Drivers 1–4 target your practice; Driver 5: Aligned Payment Reform includes change concepts and specific tactics for payers.

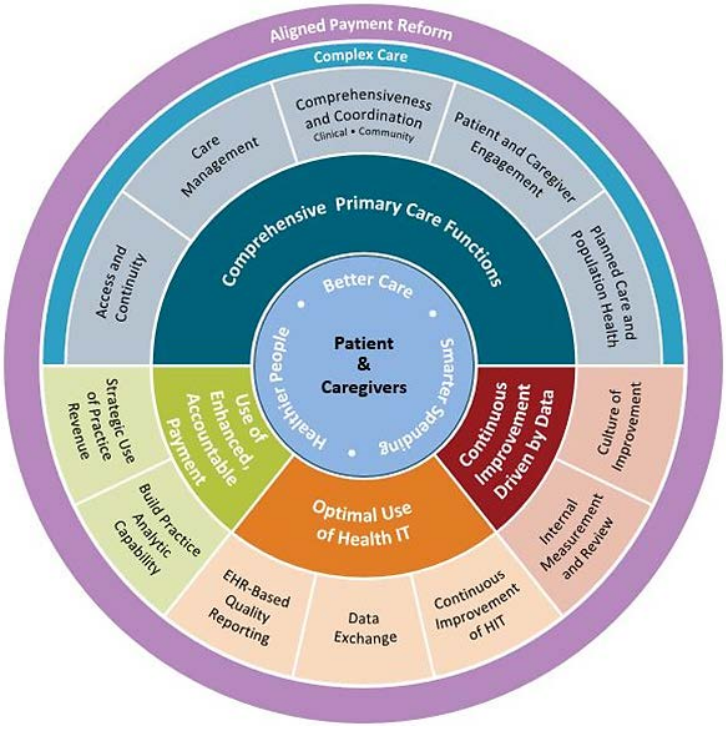


Figure 1: CPC+ Driver Diagram

Your practice is required to implement high-value change tactics tied to the Comprehensive Primary Care Functions, which will guide your practice through the work of practice change. CMS will advance and refine these requirements throughout the course of CPC+. Your practice will report on your progress in fulfilling these requirements every four or six months, depending on the measure. Change tactics presented below are specific examples of successful implementation of the care model. These tactics illustrate specific changes in care delivery that your practice can make. Your practice can meet the 2017 CPC+ care delivery requirements by using some or all of these tactics.

# CPC+ CHANGE PACKAGE

## *DRIVER 1: Five Comprehensive Primary Care Functions*

### FUNCTION 1: Access and Continuity

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

Access and Continuity Change Concepts and Tactics

| Function | Change Concept | Change Tactic |
|---|---|---|
| **1 Access and Continuity** | **A. Empanel all patients to a provider and/or care team** | 1. Assign responsibility for the total population, linking each patient to a provider and/or care team |
| | **B. Ensure timely access to care** | 1. Provide 24/7 access, guided by the medical record, to provider or care team for advice about urgent and emergent care; for example, through:<br>o The provider/care team with real-time access to medical record<br>o Cross-coverage with access to medical record<br>o Protocol-driven nurse line with access to medical record or ability to escalate to a provider with access |
| | | 2. Expand office hours in early mornings, evenings, and weekends with access to the patient medical record, either directly through the practice or through coordination with other providers |
| | | 3. Use alternatives for care outside of the traditional office visit to increase access to care team and provider, such as e-visits, phone visits, group |

| Function | Change Concept | Change Tactic |
|---|---|---|
| | | visits, home visits, and visits in alternate locations (e.g., senior centers and assisted living centers) captured in the medical record |
| | | 4. Provide same-day or next-day access to the patient's own provider or care team for urgent care or transition management |
| | | 5. Use a patient portal and secure messaging for patient and designated caregiver access to health information in languages that align with the patient population |
| | **C. Optimize continuity with provider and care team** | 1. Ensure that all providers within the practice and all members of the care team have access to the same patient information to guide care within the electronic health record (EHR) |
| | | 2. Measure and analyze care continuity between patient and provider and/or care team using health IT, scheduling systems, payer reports, or a small sample of visits or other encounters |
| **Access and Continuity Requirements** | https://innovation.cms.gov/Files/x/cpcplus-practicecaredlvreqs.pdf | |

## FUNCTION 2: Care Management

Care management for high-risk, high-need patients is a hallmark of comprehensive primary care. Through your work in CPC+, you will identify those patients in two ways. First, you will systematically risk-stratify your empaneled population to identify the high-risk patients most likely to benefit from targeted, proactive, relationship-based (longitudinal) care management. Second, you will identify patients based on event triggers (e.g., transition of care setting or new diagnosis of major illness) for episodic (short-term) care management regardless of risk status.

Your practice will provide both longitudinal and episodic care management, targeting the care management to best improve outcomes for these identified patients. You will guide your care management efforts by analyzing internal monitoring and payer data, and by using care plans focused on goals and strategies congruent with patient choices and values.

Care Management Change Concepts and Tactics

| Function | Change Concept | Change Tactic |
|---|---|---|
| **2 Care Management** | **A. Assign and adjust risk status for each patient** | 1. Use a consistent method to assign and adjust risk status for all empaneled patients: the first step is an algorithm-based method and the second step adds information that the clinical team has about the patient |
| | | 2. Monitor the risk-stratification method and ensure accuracy of risk status identification |
| | **B. Provide longitudinal care management to patients at high risk for adverse health outcome or harm** | 1. Use the risk stratification process to identify and target care management services to patients who the team believes to be at high risk and amenable to outreach |
| | | 2. Use on-site, non-physician, practice-based, or integrated shared care managers to proactively monitor and coordinate care for the highest-risk cohort of patients, with assistance from other practice staff, as needed |
| | | 3. Use a personalized care plan for patients at high risk for adverse health outcome or harm, integrating patient goals, values, and priorities |
| | **C. Provide episodic care management, including management across transitions and referrals** | 1. Provide care management services to patients with recent emergency department (ED) visits or hospitalization. Services include care transition planning and follow-up, and ensuring diagnosis and discharge plans are understood by patients and families |

| Function | Change Concept | Change Tactic |
|---|---|---|
| | | 2. Partner with community or hospital-based transitional care services to improve care transitions and reduce readmissions |
| **Care Management Requirements** | https://innovation.cms.gov/Files/x/cpcplus-practicecaredlvreqs.pdf | |

## FUNCTION 3: Comprehensiveness and Coordination

Comprehensiveness in the primary care setting refers to your practice meeting the majority of your 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 overall lower utilization and costs, less fragmented care, and better health outcomes.

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

Your practice will act as the hub of care for your patients, playing a central role in helping patients and caregivers navigate and coordinate care. Your practice 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. You will work to understand where your patients receive care and organize your practice to deliver or coordinate care in the way that achieves the best outcomes.

Comprehensiveness and Coordination Change Concepts and Tactics

| Function | Change Concept | Change Tactic |
|---|---|---|
| **3 Comprehensiveness and Coordination** | **A. Routinely assess, link, and support patients' complex health needs** | 1. Use payer and EHR data to identify conditions and needs prevalent in the practice's patient population that add to medical complexity (e.g., multi-morbidity, end of life care, polypharmacy, dementia and frailty, and health-related social needs) |
| | | 2. Establish a process for assessing, documenting, and periodically reassessing patient health care goals, health-related social needs, as well as their choices regarding advance directives and health care surrogates |
| | | 3. Regularly assess caregiver social and emotional needs and provide or facilitate caregiver support as a routine component of care |

| Function | Change Concept | Change Tactic |
|---|---|---|
| | | 4. Build a regular process to link patients with identified social needs to community-based resources for support and consider co-locating resources |
| | **B. Integrate behavioral health services to support patients' common and complex behavioral health needs** | 1. Use evidence-based treatment protocols, assess response with validated measures, and treat to goal, where appropriate |
| | | 2. Use evidence-based screening and case-finding strategies to identify individuals at risk and in need of behavioral health services |
| | | 3. Ensure regular communication and coordinated workflows between primary care, behavioral health providers, and community services |
| | | 4. Establish care coordination agreements with mental health providers that set expectations for documented flow of information and provider expectations between settings |
| | | 5. Conduct regular case reviews for at-risk or unstable patients and those who are not responding to treatment |
| | | 6. Use a registry or health IT registry functionality to support active care management and outreach to patients in treatment |
| | | 7. Facilitate integration through co-location of services (e.g., co-located social worker, psychiatric nurse practitioner, psychologist, or psychiatrist), when appropriate and feasible |
| | | 8. Implement screening with brief intervention for alcohol and other substance misuse |
| | | 9. Train clinical staff to deliver behavioral health therapies (e.g., train nurse care managers to provide Problem Solving Therapy) |
| | **C. Manage medications to maximize efficiency, effectiveness, and safety** | 1. Reconcile and coordinate medications and provide medication management across transitions of care settings and providers |

| Function | Change Concept | Change Tactic |
|---|---|---|
| | | 2. Provide medication self-management support to improve adherence to prescribed medication |
| | | 3. Integrate a pharmacist into the care team to provide medication management services |
| | | 4. Conduct comprehensive medication reviews with action plans, individualized therapy goals, and planned follow-up, particularly for high-risk patients who:<br>o Experience a transition of care<br>o Receive longitudinal care management<br>o Take high-risk medication |
| | | 5. Work together with pharmacists and other health care professionals to promote clinically sound, cost-effective medication therapy and therapeutic outcomes (i.e., provide formulary management) |
| | | 6. Implement robust medication reconciliation at regular, established intervals, including assessment of medication regimens for missing yet indicated medications, and those not needed or indicated |
| | **D. Provide effective care coordination, navigation, and active referral management in the medical neighborhood** | 1. Ensure routine and timely follow-up to ED visits and hospitalizations |
| | | 2. Establish care coordination agreements with frequently used or high-cost specialists and or care agencies (e.g., home health agencies and skilled nursing facilities) that set expectations for documented flow of information and provider expectations between settings |
| | | 3. Guide, track, and follow up with patients referred to specialists |
| | | 4. Develop a process for sharing information regarding patient health care goals, as well as their choices regarding advance directives and health care surrogates, with consultants and other providers in the medical neighborhood (e.g., acute care facility) |
| | | 5. Systematically integrate information from referrals into the plan of care |

| Function | Change Concept | Change Tactic |
|---|---|---|
| | | and help patients understand the information provided in the referral response |
| | **E. Establish effective linkages with neighborhood/ community-based resources to support patient health goals and health-related social needs** | 1. Use and integrate a health-related social need screening tool/question(s) that will identify community and social service needs among the patient population, including a universal screening for all patients and a targeted screening for patients with complex needs |
| | | 2. Inventory and maintain/access a current database of community and social services that is updated and refined regularly |
| | | 3. Provide patients with effective coordination with community and social services by following up with patients at regular intervals |
| | | 4. Build relationships and formalize coordination agreements around information sharing and linkages with culturally competent community-based initiatives and agencies/services (e.g., personal care services, homemaker services, nutrition services, home modifications, transportation, assistive technology, respite care, legal assistance, food, and other basic needs) |
| | | 5. Track and measure success rates of linkages to community resources |
| | **F. Increase capability to manage medical conditions in the primary care setting that meet the needs of the practice population** | 1. Review data from CMS and other payers to identify common health conditions seen in the population and to identify specialty use for common chronic conditions. Develop a strategy to increase knowledge and skills to address these conditions and needs in the primary care practice |
| | | 2. Expand collaboration with specialists to include strategies such as co-location and co-management for common conditions |
| **Comprehensiveness and Coordination Requirements** | https://innovation.cms.gov/Files/x/cpcplus-practicecaredlvreqs.pdf | |

## FUNCTION 4: Patient and Caregiver Engagement

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

Patient and Caregiver Engagement Change Concepts and Tactics

| Function | Change Concept | Change Tactic |
|---|---|---|
| **4 Patient and Caregiver Engagement** | **A. Engage patients and caregivers to guide improvement in the system of care** | 1. Establish a PFAC to work on procedures, processes, and quality improvement strategies to achieve high-quality coordinated and patient and family centered care in the practice |
| | | 2. Ensure that patients are directly involved in the practice's transformation team |
| | | 3. Communicate to patients, families, and caregivers about the changes being implemented by the practice |
| | | 4. Regularly assess the patient care experience and engage patients as partners through surveys and/or other mechanisms |
| | **B. Integrate self-management support into usual care across conditions** | 1. Incorporate evidence-based approaches to promote collaborative self-management into usual care using techniques such as goal setting with structured follow-up, Teach Back, action planning, and motivational interviewing |
| | | 2. Use tools to assist patients in assessing their need for and receptivity to self-management support (e.g., the Patient Activation Measure or How's My Health) |
| | | 3. Use group visits for common chronic conditions (e.g., diabetes) |
| | | 4. Provide condition-specific chronic disease self-management support programs or coaching, or link patients to those programs in the community |
| | | 5. Provide self-management materials at an appropriate literacy level and in an appropriate language |

| Function | Change Concept | Change Tactic |
|---|---|---|
| | | 6. Use a shared agenda for the visit and provide heath coaching between visits |
| | **C. Engage patients in shared decision making** | 1. Engage patients in shared decision making about risk and benefits of testing and treatments, where guidelines identify the decision as preference-sensitive |
| | | 2. Use evidence-based decision aids to support shared decision-making |
| **Patient and Caregiver Requirements** | https://innovation.cms.gov/Files/x/cpcplus-practicecaredlvreqs.pdf | |

## FUNCTION 5: Planned Care and Population Health

Your practice will organize your care to meet the needs of the entire population of patients you serve. Using team-based care, you will proactively offer timely and appropriate preventive care, and consistent evidence-based management of chronic conditions. You 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 levels.

Planned Care and Population Health Change Concepts and Tactics

| Function | Change Concept | Change Tactic |
|---|---|---|
| **5 Planned Care and Population Health** | **A. Use team-based care to meet patient needs efficiently** | 1. Define roles and distribute tasks among care team members, consistent with their skills, abilities, and credentials, to better meet patient needs effectively and efficiently |
| | | 2. Use pre-visit planning and huddling inclusive of all key roles on the care team to optimize preventive care and care team management of patients with chronic conditions, including medical and health-related social needs |
| | | 3. Use decision support tools and protocols to manage workflow in the team to meet patient needs |
| | | 4. Analyze and manage workflow to address chronic and preventive care, including health-related social needs (e.g., through pre-visit planning and/or huddles) |
| | | 5. Enhance team resources with staff – such as a health coach, nutritionist, behavioral health specialist, pharmacist, physical therapist, community resource specialist, social worker, patient navigator, and/or health educator – as feasible to meet the needs of the population |
| | **B. Proactively manage chronic and preventive care for empaneled patients** | 1. Use condition-specific pathways of care for common chronic conditions in the practice population (e.g., hypertension, diabetes, depression, asthma, and heart failure) with evidence-based protocols to guide treatment, and measure key quality indicators (e.g., electronic Clinical Quality Measures [eCQMs] and utilization metrics) for those conditions |

| Function | Change Concept | Change Tactic |
|---|---|---|
| | | 2. Use panel support tools (e.g., registry functionality, reminders, phone calls, emails, post cards, text messaging, community health worker where available) to identify, alert, and educate patients about regular services due and overdue, while also identifying patients for whom services otherwise due are inapplicable and why |
| | | 3. Use data (e.g., from registry and payers) to identify populations or groups of patients with similar needs and challenges to select high-priority areas for improvement |
| | | 4. Meet with care teams regularly to review performance on the available metrics including quality and costs that define value for patient subgroups |
| **Planned Care and Population Health Requirements** | https://innovation.cms.gov/Files/x/cpcplus-practicecaredlvreqs.pdf | |

## *DRIVER 2: Use of Enhanced, Accountable Payment*

Enhanced, Accountable Payment Change Concepts and Tactics

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

## *DRIVER 3: Continuous Improvement Driven by Data*

Continuous Improvement Change Concepts and Tactics

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

| Secondary Driver | Change Concept | Change Tactic |
|---|---|---|
| | | measures used to guide practice change |
| | | 3. Access available expertise to assist in practice changes of strategic importance to the practice |

## *DRIVER 4: Optimal Use of Health IT*

Health IT Change Concepts and Tactics

| Secondary Driver | Change Concept | Change Tactic |
|---|---|---|
| **4.1 Continuous Improvement of Health IT** | **A. Use ONC-certified EHR technology (CEHRT) and report to Merit-Based Incentive Payment System (MIPS) to meet the Meaningful Use EHR technology performance category** | 1. Use latest version of ONC-certified EHR technology |
| | | 2. Align practice changes for Comprehensive Primary Care with the Meaningful Use of CEHRT MIPS performance category requirements |
| | **B. Develop practice capacity for optimal use of EHR** | 1. Cross-train staff in key skills in the use of Health IT to improve care |
| | | 2. Convene regularly to discuss and improve workflows to optimize EHR use |
| | | 3. Engage regularly with EHR and other Health IT vendors about Health IT requirements to deliver efficiently the five Comprehensive Primary Care Functions and for EHR-based quality reporting |
| | | 4. Identify a Health IT champion to work on improving Health IT used in practice, teach team, and establish workflows for EHR documentation |
| **4.2 Data Exchange** | **A. Enable the exchange of patient information to support care** | 1. Connect to local health information exchanges, if available |
| | | 2. Develop information exchange processes with other service providers with which the practice shares patients |
| | | 3. Use standard documents created by the EHR to routinely share information (e.g., medications, problems, allergies, goals of care, etc.) at time of referral and transition between settings of care |
| | | 4. Use non-clinical workflows to systematically enter structured clinical data from external (e.g., paper and e-fax) sources into the EHR |
| **4.3 EHR-Based Quality Reporting** | **A. Develop the capability for practice- and panel-level quality measurement and reporting from the EHR** | 1. Develop capability for practice-level reporting of Clinical Quality Measures derived from the EHR |
| | | 2. Develop capability for panel-level reporting of Clinical Quality Measures derived from the EHR |

| Secondary Driver | Change Concept | Change Tactic |
|---|---|---|
| | | 3. Develop capability for electronic transmission of quality measure reports |

## *DRIVER 5: Aligned Payment Reform*

Aligned Payment Reform Change Concepts and Tactics for CPC+ payer partners

| Secondary Driver | Change Concept | Change Tactic |
|---|---|---|
| **5.1 Aligned Payment Reform** | **A. Use population-based payment to purchase comprehensive primary care services** | 1. Prospectively align every member or beneficiary with a primary care provider, care team, or practice |
| | | 2. Provide a per-member or per-beneficiary per month supplement to fee-for-service payment for primary care services |
| | | 3. Use a methodology to risk adjust per member/beneficiary per month payment, and share methodology with practices |
| | | 4. Align standards for comprehensive primary care services across the CPC+ payers |
| | | 5. Track 2 Only: Shift payment from fee-for-service to alternative forms of payment to compensate the care team for proactive, efficient, and comprehensive care that would otherwise be furnished in a traditional office visit |
| | **B. Provide actionable and timely cost and utilization data to practices** | 1. Provide at least quarterly reports of timely data, by provider and practice, of services received by members/beneficiaries outside of the primary care practice |
| | | 2. Notify providers and practices of ED visits and admissions and discharges as soon as possible |
| | | 3. Engage with practices to improve the usability and functionality of data reports |
| | | 4. Aggregate or align cost, utilization, and quality reports with other payers engaged in CPC+ |
| | **C. Reward practice actions to reduce total cost of care through a PBIP** | 1. Use alternative financial incentives to reward achievement of better care, smarter spending, and healthier people |
| | | 2. Seek alignment between payment incentives, contract terms, and the five Comprehensive Primary Care Functions |

| Secondary Driver | Change Concept | Change Tactic |
|---|---|---|
| | **D. Align quality measures** | 1. Align with CMS and other CPC+ partner payers in a region on all three types of performance-based quality measures (i.e., eCQMs, patient experience (CAHPS) measures, and utilization measures) |