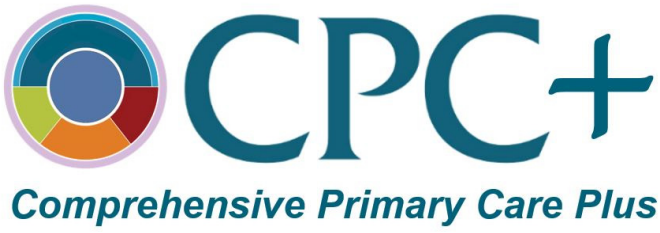

2017 CPC+ CARE DELIVERY REPORTING GUIDE

March 2017

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CARE DELIVERY REPORTING GUIDE

Introduction

This document guides you through the 2017 CPC+ Care Delivery Reporting. Your practice should use this guide to prepare for reporting in each quarter, and identify what information you will need to collect and track. This guide includes all questions, reporting frequency, definitions, and other notes to help you understand the reporting requirements. We recommend reading the questions ahead of time and using them as a way to meet with your practice team in facilitating the reporting process and identifying the best person for reporting data by each section. Some questions require input from different staff members in your practice, and, data acquired in your EHR, or other data applications.

The information you collect and provide is incredibly valuable: it allows you to track your progress and direct efforts to implement the CPC+ Care Delivery Requirements in accordance with the five comprehensive care functions. Your answers allow us to learn about your practice's capabilities and strategies for delivery of high-value, comprehensive primary care. This will help us better understand the changes occurring in your practice and improve learning activities to support your practice in providing comprehensive primary care as defined in CPC+.

Below is a summary table with quarterly reporting periods. You will complete your reporting in the CPC+ Practice Portal.[1]

Table 1: CPC+ 2017 Reporting Submission Periods

Quarter	Submission Periods
Quarter 1	3/27/17 through 4/14/17
Quarter 2	6/26/17 through 7/14/17
Quarter 3	9/25/17 through 10/13/17
Quarter 4	12/25/17 through 1/19/18

The tables below cross-references each reporting item and the quarter in which a response is required. Table 2 references the frequency of reporting for Year 1. Table 3 references the reporting items for the Quarter 1. When denoted by (•), a response is required for that reporting domain only if answers need to be updated, when you need to update or change your previous response for that question.

[1] The CPC+ Practice Portal is a secure website hosted in the CMS Enterprise Portal (https://portal.cms.gov/). You can find detailed instructions on how to access the CPC+ Practice Portal in **Appendix B** of the **Phase 1 CPC+ Implementation Guide**.

Table 2: PY 2017 Reporting by Quarter

Care Delivery Change Title					
Function 1: Access and Continuity		Q1	Q2	Q3	Q4
1.1	24/7 Access	●		●	
1.2	Enhanced Access and Communication		●		●
1.3	Empanelment	●	●	●	●
1.4	Continuity of Care	●		●	
Function 2: Targeted Care Management		Q1	Q2	Q3	Q4
2.1	Risk Stratification		●		●
2.2	Identifying Patients for Care Management	●	●	●	●
2.3	Care Management Staffing	●		●	
2.4	Care Plans		●		●
2.5	Coordinating with the Hospital and EDs Your Patient Use	●	●	●	●
2.6	Medication Management	●		●	
Function 3: Comprehensiveness and Coordination		Q1	Q2	Q3	Q4
3.1	Identifying and Communicating with Hospitals and EDs Your Patients Use	●		●	
3.2	Care Compacts/ Agreements with High Volume Specialists/ Practitioners	●	(●)	(●)	(●)
3.3	Linkages with Social Services		●		●
3.4	Comprehensiveness			●	
3.5	Behavioral Health Integration		●		●
Function 4: Patient and Caregiver Engagement		Q1	Q2	Q3	Q4
4.1	Patient and Family Advisory Council	●	●	●	●
4.2	Engaging Patients and Care Givers in Your Practice		●		●
4.3	Support for Self-Management Across Conditions		●		●
4.4	Self- Management Support for Selected Conditions	●	(●)	(●)	(●)
4.5	Shared Decision Making				●
Function 5: Planned Care and Population Health		Q1	Q2	Q3	Q4
5.1	Team- Based Care	●		●	
5.2	Use of Data to Plan Care		●		●
5.3	Continuous Quality Improvement		●		●
5.4	Culture of Improvement at Your Practice		●		●
General	Reporting Point of Contact, CPC+ Payer Partners, Patient Demographics	●	(●)	(●)	(●)

Table 3: Care Delivery Reporting Period Quarter One (3/17 – 4/14)

Care Delivery Change Title	
Function 1: Access and Continuity	
1.1	24/7 Access
1.3	Empanelment
1.4	Continuity of Care
Function 2: Targeted Care Management	
2.2	Identifying Patients for Care Management
2.3	Care Management Staffing
2.5	Coordinating with the Hospital and EDs Your Patient Use
2.6	Medication Management
F unction 3: Comprehensiveness and Coordination	
3.1	Identifying and Communicating with Hospitals and EDs Your Patients Use
3.2	Care Compacts/ Agreements with High Volume Specialists/ Practitioners
Function 4: Patient and Caregiver Engagement	
4.1	Patient and Family Advisory Council
4.4	Self- Management Support for Selected Conditions
Function 5: Targeted Care Management	
5.1	Team- Based Care
General	Reporting Point of Contact, CPC+ Payer Partners

Care Delivery Questions

Function 1: Access and Continuity

<table>
<tr><td>1.1 24/7 Access</td><td rowspan="2">Notes</td></tr>
<tr><td>Reporting Periods: Quarters 1 and 3</td></tr>
<tr><td>Is 24/7 coverage provided with real-time access to your practice's EHR?
○ Yes
○ No</td><td>Real-time refers to having access to current, up-to-date medical records in the EHR during off hours.</td></tr>
<tr><td>Does a clinician or care team member from your practice site usually provide 24/7 coverage?
○ Yes
○ No, we have a centralized call-center for our health system (after-hours coverage for all practices in the system)
○ No, we have a formal coverage arrangement with another practice/ organization</td><td>A care team is a group of individuals at your practice who work together to care for a specific panel of patients. The care team member providing 24/7 coverage must be a licensed medical practitioner (i.e., MD/DO, NP, PA).</td></tr>
<tr><td>1.2 Enhanced Access and Communication</td><td rowspan="2">Notes</td></tr>
<tr><td>Reporting Periods: Quarters 2 and 4</td></tr>
<tr><td>When patients need it, my practice is able to provide…
<table><tr><th></th><th>Never</th><th>Rarely</th><th>Some-times</th><th>Often</th><th>Always</th></tr><tr><td>… same or next-day appointments</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>… office visits during expanded hours on the weekend, evening, or early morning</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>… telephone advice on clinical issues during office hours</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>… telephone advice on clinical issues on weekends and/or after regular office hours</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>… email or portal advice on clinical issues</td><td></td><td></td><td></td><td></td><td></td></tr></table></td><td></td></tr>
</table>

What functions can patients perform through your practice's secure patient portal? (Select all that apply)

- ☐ My practice does not have a secure patient portal available for patients
- ☐ Communicate with the care team
- ☐ Access lab/test results and clinical notes
- ☐ Schedule appointments
- ☐ Other: (textbox)

Note: If you select 'My practice does not have a secure patient portal available for patients,' you will be unable to select the other options for this question.

Does your practice provide any of the following types of alternative visits (billable under traditional fee-for-service)?

	Total number of this type of visit provided in the last quarter	Who primarily provided this service? (Select all that apply)						
		MD/ DO	NP/ PA	RN	MA	LPN	RD	Other: (textbox)
Home visits (i.e. primary care home visits)		☐	☐	☐	☐	☐	☐	☐
Medical group visits (e.g., shared medical appointments)		☐	☐	☐	☐	☐	☐	☐
Group education classes (e.g. DSME Diabetes Self-Management Education)		☐	☐	☐	☐	☐	☐	☐
Preventive counseling services (e.g., reimbursable counseling for obesity, alcohol misuse, tobacco cessation)		☐	☐	☐	☐	☐	☐	☐
Medical nutrition consultation visits		☐	☐	☐	☐	☐	☐	☐
Visits in alternative locations (e.g., nursing facilities, hospitals, senior centers)		☐	☐	☐	☐	☐	☐	☐
Telehealth (or telemedicine) and e-Visits		☐	☐	☐	☐	☐	☐	☐
Remote monitoring		☐	☐	☐	☐	☐	☐	☐
Other: (textbox)		☐	☐	☐	☐	☐	☐	☐

This question refers to medical services that go beyond traditional face-to-face office-based visits that are currently reimbursable services through traditional fee-for-service billing

You will only have to provide information for the type of visits your practice is providing. You can use billing data or scheduling to provide an accurate number of billable visits.

Note: Track 2 practices are required to develop the capacity for alternative visits in 2017, and your practice may have used or plan to use the CPCP for this work, in addition to or instead of FFS billing.

(Optional) In addition to the alternative visit types described in the table above, what ways has your practice used Comprehensive Primary Care Payments to increase access outside of the traditional office visit? (textbox)

Note: This question is for Track 2 CPC+ practices only. The Comprehensive Primary Care Payment (CPCP) is intended to support the flexible delivery of care to promote population health beyond traditional office visits.

1.3 Empanelment

Reporting Periods: Quarterly

Notes

Do you primarily empanel patients by practitioner (i.e., each MD, DO, PA, or NP) or by care team (i.e., practitioner-led teams)?

- ○ Practitioner
- ○ Care Team

A care team is a group of individuals at your practice who work together to care for a specific panel of patients.

Empanelment Status	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Number of panels at your practice:				
Total number of patients empaneled with a practitioner or care team at your practice:				
Total number of active patients at your practice:				
% of patients empaneled				

Active patients for purposes of this table are patients who received care at your practice recently. A typical look-back period to identify active patients is at least a year, and usually 18 to 36 months, depending on your practice.

The grey table cells with a diagonal pattern indicate a title cell or content that is auto-calculated.

What is your active patient look-back period?

- ○ Less than one year
- ○ 1-2 years
- ○ More than two years

1.4 Continuity of Care

Reporting Periods: Quarters 1 and 3

Notes

Do you track continuity of care (in terms of how often patients see the practitioner or care team to which they are empaneled) for your patients?

- ○ Yes

  What system(s) do you primarily use to track continuity of care? (Select all that apply)

  - ☐ EHR
  - ☐ Electronic practice management systems (e.g., appointment scheduling system)
  - ☐ Other: (text box)

- ○ No

***Continuity of care** refers to an ongoing relationship between a patient and the practitioner(s) or care team to which they are empaneled.*

Note: If you answer 'Yes,' the question asks for further details. If you answer 'No,' the next question is automatically skipped.

What scheduling strategies do you use to optimize continuity of care? (Select all that apply) ☐ We do not use any strategies to optimize continuity of care ☐ Open scheduling ☐ Same day scheduling for urgent/acute care ☐ Tools to help patients identify their practitioner or care team (e.g., practitioner and care team photos on practice website) ☐ Other: (textbox)	*Note: If you select 'We do not use any strategies,' you will be unable to select the other options for this question.*

Function 2: Targeted Care Management

2.1 Risk Stratification **Reporting Periods: Quarters 2 and 4**	**Notes**
What type of **data-driven algorithm** do you use for risk stratifying your patients? (Select all that apply) ☐ We do not use a data-driven algorithm as part of our risk stratification ☐ Algorithm based on claims variables ☐ Algorithm based on clinical variables from the EHR ☐ Published clinical algorithm (e.g., AAFP risk tool) ☐ Other: (textbox)	*All practices must identify and prioritize a methodology to risk stratify all empaneled patients. Track 2 practices must further use a two-step risk stratification process:* *• Step 1 - based on defined diagnoses, claims, or another algorithm (i.e., not care team intuition);* *• Step 2 - adds the care team's perception of risk (care team/ clinical intuition) to adjust the risk-stratification of patients, on an as needed basis.*
What other factors do you consider when using **care team/clinical intuition** to stratify your patients? (Select all that apply) ☐ We do not use the care team's perception as part of our risk stratification ☐ Social needs ☐ Behavioral health needs ☐ Clinical factors that are not included in the algorithm ☐ Other: (textbox)	***Clinical intuition/care team perception*** *is a practitioner's and/or care team's knowledge of a patient and a global assessment of their risk, which may include clinical, social, and behavioral risk. This is the second step in the risk-stratification process required of Track 2 practices.* *Note: If you select 'We do not use the care team's perception,' you will be unable to select the other options for this question.*

What prompts reassessment of a patient's risk stratification assignment?
○ N/A
○ Ad hoc, or only as needed
○ Pre-specified clinical events (e.g., new diagnosis, hospitalization)
○ Automatically updated when new information is in the health IT or EHR platform
○ Schedule-driven protocol
  ○ At each visit
  ○ Every three to six months
  ○ Annually
  ○ Other: (textbox)
○ Other: (textbox)
	Note: If you select 'Schedule-driven protocol,' you will be prompted to indicate the frequency.

What system do you use for risk stratification? ☐ EHR-based platform ☐ Health IT or analytic platform that **is integrated** with the EHR ☐ Health IT or analytic platform that **does not integrate** with the EHR ☐ Other: (textbox)	

2.2 Identifying Patients for Care Management

Reporting Periods: Quarterly

In the table below, please tell us how your patient population is risk stratified, using your practice's chosen risk stratification method.

Level of Risk *(highest risk at the top)*	Total number of patients in this tier	Number of patients in this tier under longitudinal-al care manage-ment	% of total empaneled patients in this risk tier	% of patients in this risk tier under longitudinal-al care management	This tier is used to target patients for care management
Not assigned					
Total empaneled patients					

Notes

Longitudinal care manage-ment *is intensive, ongoing, relationship-based care for patients at highest risk for adverse, preventable outcomes. For this table, report your patient counts based on a convenient day or moment, as close as possible to the last day of the reporting quarter:*

- ***Level of Risk:*** *Generate a row for each risk tier in your risk stratification method, and label the rows using the terminology your practice uses to define risk. Place risk tiers in descending order, with the highest risk tier at the top, and the lowest at the bottom.*
- ***Total number of patients in this tier:*** *Indicate the number of patients in each risk tier using your practice's chosen risk stratification method.*
- ***Number of patients under longitudinal care:*** *Indicate the number of patients in each risk tier who were targeted for and received ongoing, longitudinal care management.*
- ***% of total empaneled patients:*** *This column will auto-calculate the percentage of empaneled patients in the risk tier*
- ***% of patients under longitudinal care management:*** *This column will auto-calculate the percentage of active patients who are under care management*
- ***Target patients for care management:*** *Mark the tier(s) used to target patients for longitudinal care management. For example, your practice may target patients for care management based on the highest risk tier.*

Note: The grey table cells indicate title cells and the table cells with a diagonal pattern indicate content that is auto-calculated.

	Q1	Q2	Q3	Q4
% of patients under care management out of total empaneled				
% of patients risk-stratified out of total empaneled				

Note: This table is auto-populated to help you track rates over time. For example, in Quarter 2, your Quarter 1 rates will be auto-populated and included in this column.

The grey table cells indicate title cells and the table cells with a diagonal pattern indicate content that is auto-calculated.

Indicate how you identify patients for episodic care management. This refers to short term, goal directed care management for **patients who are not already in longitudinal care management** as a result of their risk status. (Select all that apply)

- ☐ Hospital admission
- ☐ ED visit
- ☐ New health condition (e.g., cancer diagnosis, accident, chronic condition)
- ☐ New clinical instability in a chronic condition, including change in medications
- ☐ Life event (e.g., death of spouse, financial loss)
- ☐ Initiation or stabilization on a high risk medication (e.g., anticoagulants)
- ☐ Other: (text box)

***Episodic care management** is short-term, goal-directed care for patients who your practice has not already targeted for longitudinal care management.*

2.3 Care Management Staffing

Reporting Periods: Quarters 1 and 3

What type of clinician and staff at your practice is/are **primarily responsible** for each of the following care management and coordination activities? **(Select all that apply)**

Activities	None	MD/DO	NP/PA	RN	MA	SW	Other
Developing and monitoring care plans	☐	☐	☐	☐	☐	☐	☐
Assessing and reassessing patient risk status	☐	☐	☐	☐	☐	☐	☐
Providing patient education and self-management support	☐	☐	☐	☐	☐	☐	☐
Coordinating care transitions (Hospital, ED discharges)	☐	☐	☐	☐	☐	☐	☐
Coordinating and communi-cating with specialty care	☐	☐	☐	☐	☐	☐	☐
Navigating patients to community and social services	☐	☐	☐	☐	☐	☐	☐
Clinical monitoring and following up with specific patients	☐	☐	☐	☐	☐	☐	☐
Scheduling needed appointments and tests	☐	☐	☐	☐	☐	☐	☐

Notes

Please limit this to the staff at your practice who spend the most amount of time on these activities, even if it is not their primary duty. If no one at your practice is performing these activities, then select 'None' at the leftmost column of the table.

For example, if MAs at your practice do the bulk of follow-up calls to patients, but an RN sometimes fills in, the MA is the person primarily responsible for this activity. If an MA and an RN equally split the coordination, then select both.

2.4 Care Plans

Reporting Periods: Quarters 2 and 4

Does your practice use care plans for patients under longitudinal care management?

- ○ No, we **do not use** care plans in our care management process.
- ○ We use care plans for **some** patients, on an ad hoc basis.
- ○ We use care plans for **some** patients, targeted based on conditions or other factors.
- ○ We systematically implement care plans for **all or most** patients under care management

Notes

A care plan is a mutually agreed upon and documented plan of care based on the patient's goals and available medical evidence, and is accessible to all team members providing care for the patient.

For purposes of CPC+, "care plans" and "plans of care" are used synonymously.

Note: If you answer 'No, we do not use care plans,' the following questions are skipped and you will move onto Section 2.5.

Do you have a routine process for monitoring, updating, and reviewing care plans? ○ Yes When are care plans reviewed and updated? ☐ Pre-specified changes in clinical status (e.g., new diagnoses, injuries, and exacerbations of illness) ☐ Routinely on a time-based schedule (e.g., monthly or at every visit) ☐ Other: (textbox) ○ No	*Note: If you answer 'Yes', the question asks for further details.*
Do you document and store care plans? ○ No ○ Yes, care plans are **integrated** with the EHR ○ Structured field ○ Unstructured note ○ Other: (textbox) ○ Yes, care plans are documented and stored but **not integrated** with the EHR ○ Patient portal ○ After-visit summary ○ Standalone system or module in EHR not integrated with patient records ○ Other: (textbox)	*Note: If you answer 'Yes', the question asks for further details.*
What type(s) of information are typically included in care plans? (Select all that apply) ☐ Treatment goals and interventions as identified by the care team ☐ Medication adjustments for changes in condition ☐ Patient's overall health goals ☐ Patient/caregiver's plans for self-management ☐ Patient/caregiver's plans for acute changes in condition ☐ Advance directives and preferences of care ☐ Plan for next update or review of care plan with patient and care team ☐ Contact information for practitioners and services involved in the patient's care, including contact options for after-hours coverage ☐ Other: (textbox)	

Who has real-time/point of care access to a patient's care plan? (Select all that apply)

- ☐ Members of the care team within the practice
- ☐ Clinicians outside of the practice (i.e. other specialists who care for the patient)
- ☐ Community and/or social service agencies or practitioners who care for the patient
- ☐ Patient and his/her caregiver(s)
- ☐ Other: (textbox)

***Real-time** refers to having access to current, up-to-date medical records in the EHR.*

How are care plans shared with patients and caregivers? (Select all that apply)

- ☐ Care plans are not shared with patients in a systematic way
- ☐ Patient portal
- ☐ At the time of a face-to-face visit
- ☐ Incorporated in the after-visit summary
- ☐ Other: (textbox)

Note: If you select 'Care plans are not shared with patients in a systematic way', you will be unable to select any other options.

2.5 Coordinating with the Hospitals and EDs Your Patients Use

Note

Reporting Periods: Quarterly

Identify the top hospital(s) and emergency departments (EDs) that your patients **generally** used the most over the last quarter.

Name of Hospital/ED	Hospital only	ED only	Both hospital and ED
A			
B			
C			

*Top hospital(s) and emergency departments (EDs) are those hospital/EDs **used by the majority** of your patients. For example, if you are in an area with multiple hospitals, list up to three hospitals that are utilized most frequently by your patients.*

Indicate if each site you list here is used for just hospital admissions, ED visits, or both.

2.5.1 In the table below, provide the counts of your patients discharged from the emergency department (ED) during this quarter and those who received follow-up contact within one week after visiting the ED. This table auto populates based on which ED(s) you indicated in 2.5.

Name of ED (Generated from the table above)	Number of patient discharges from this ED	Number of patient discharges from this ED with follow-up within one week	% of discharges with follow-up within one week	We do not track discharges from this ED
A				
B				
C				
Overall discharges and follow-ups				

Overall Rate	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Overall ED follow-up rate				

*In the table, provide the counts of your **empaneled patients** discharged from the **emergency department (ED)** during the reporting quarter and those who received follow-up contact within one week after visiting the ED. Note that an individual patient may have more than one discharge, and we are counting the number of discharges, not patients.*

This table asks you to report on total numbers for the reporting quarter. For example, the Quarter 1 date range is 1/1/17-3/31/17.

- ***Name of ED:** A row is generated for each ED you listed in the previous question.*
- ***Number of patient discharges:** Indicate the number of empaneled patient discharges during the reporting quarter.*
- ***Number of patient discharges with follow-up:** Indicate the number during the reporting quarter.*
- ***% of discharges with follow-up:** This column will auto-calculate*
- ***We do not track discharges:** If you select this, you will not be able to enter discharge or follow-up numbers for those ED(s).*

Note: The overall rates for discharges and follow-ups are auto-calculated once all of your data has been entered. The grey table cells indicate title cells and the table cells with a diagonal pattern indicate content that is auto-calculated.

2.5.1 In the table below, provide the counts of your patients discharged from the hospital during this quarter and those who received follow-up contact within two business days after hospital discharge. This table auto populates based on which Hospital(s) you indicated in 2.5.

Name of Hospital	Number of patient discharges from this hospital	Number of patient discharges followed by contact within 72 hours or 2 business days	% of discharges with follow-up within 72 hours or 2 business days	We do not track discharges from this hospital (checkbox)
A				
B				
C				
Overall discharges and follow-ups				

Overall Rate	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Overall Hospital follow-up rate				

*In the table, provide the counts of your **empaneled patients** discharged from the **hospital** during this quarter and those who received follow-up contact within one week after visiting the hospital. Note that an individual patient may have more than one discharge, and we are counting the number of discharges, not patients.*

This table asks you to report on total numbers for the reporting quarter. For example, the Quarter 1 date range is 1/1/17-3/31/17.

- ***Name of hospital:** A row is generated for each hospital you listed in the previous question.*
- ***Number of patient discharges:** Indicate the number during the reporting quarter.*
- ***Number of patient discharges with follow-up:** Indicate the number during the reporting quarter.*
- ***% of discharges with follow-up:** This column will auto-calculate*
- ***We do not track discharges:** If you select this, you will not be able to enter discharge or follow-up numbers for those ED(s).*

Note: The overall rates for discharges and follow-ups are auto-calculated once all of your data has been entered. The grey table cells indicate title cells and the table cells with a diagonal pattern indicate content that is auto-calculated.

2.6 Medication Management

Reporting Periods: Quarters 1 and 3

Notes

The intent of this section is to learn more about your practice's medication management strategies and activities of your practice.

What type of clinician and staff at your practice is/are primarily responsible for each of the following medication management activities? **(Select all that apply)**

Services	MD/DO	RN	Care Manager	Pharm.D	Pharmacy Tech.	Other: (textbox)
Routine medication reconciliation at scheduled visits	☐	☐	☐	☐	☐	☐
Coordination and reconciliation of medication during transitions of care	☐	☐	☐	☐	☐	☐
Comprehensive medication reviews	☐	☐	☐	☐	☐	☐
Formulary management	☐	☐	☐	☐	☐	☐
Patient support for medication use and self-management	☐	☐	☐	☐	☐	☐
Collaborative drug therapy management	☐	☐	☐	☐	☐	☐

Please limit this to the staff at your practice who spend the most amount of time on these activities, even if it is not their primary duty. If no one at your practice is performing these activities, then select 'None' at the bottom of the table.

For example, if RNs at your practice do the bulk of medication management activities, but an NP sometimes fills in, the RN is the person primarily responsible for this activity. If an NP and an RN equally split the coordination, then select both.

Note: If you select 'None', you will be unable to select any other options. Also, 'Pharm.D' in column 5 is an abbreviation for Pharmacist.

Does your practice use a specific model of care or strategy for medication management services?

- ☐ No, we do not use a specific model of care or strategy
- ☐ AMA's STEPS*forward* /SafeMed Model
- ☐ Medications at Transitions and Clinical Handoffs (MATCH) Model
- ☐ Practice developed protocol
- ☐ Other: (text box)

Note: If you select 'No' for this question, you will be unable to select the other options. If you are not familiar with a specific model of care or strategy, then do not indicate that your practice is using this approach.

How does the practice engage pharmacist(s) as part of the care team? (Select all that apply)

- ☐ We do not formally engage pharmacists
- ☐ Direct hire
- ☐ Shared resource for practices in our health system
- ☐ Contract
- ☐ Relationship with a teaching facility
- ☐ We use a non-pharmacist with prescribing authority for medication management

  Specify: (textbox)
- ☐ Other agreement: (textbox)

Note: If you select 'We do not formally engage pharmacists,' the next two questions will be automatically skipped.

How many pharmacists work at the practice? (textbox)	*Please include all pharmacists that are engaged with your care team, including those who are not physically located at your practice full-time.* *Note: If you select 'We do not formally engage pharmacists,' this question is automatically skipped.*
How many hours a week, on average, do the pharmacist(s) work at the practice? If more than one pharmacist, please add up the hours. (textbox)	*Please include the hours worked by pharmacists engaged with your care team, whether or not their services were physically provided at your practice.* *Note: If you select 'We do not formally engage pharmacists,' this question is automatically skipped.*
How do you identify patients for medication management services with a pharmacist (beyond routine medication reconciliation)? (Select all that apply) ☐ We do not systematically select patients for medication management services ☐ High risk tier based on risk stratification ☐ Not achieving a therapeutic goal for a chronic condition ☐ Experiencing a care transition(s) ☐ Direct practitioner referral ☐ Number of medications taken (poly-pharmacy) ☐ Use of high risk medication(s) ☐ Use of high cost medications(s) ☐ Other: (textbox)	*Note: If you select 'We do not systematically select patients for medication management services,' you will be unable to select the other options for this question.*

Function 3: Comprehensiveness and Coordination

3.1 Identifying and Communicating with Hospitals and EDs Your Patients Use

Reporting Periods: Quarters 1 and 3

Notes

Tell us how you coordinate and communicate about admission/ discharge/transfer (ADT) information with the hospitals and EDs where your patients seek care. This table auto-populates based on which hospitals/EDs you indicated in 2.5.

Hospital/ ED	How promptly do you receive ADT information about your patients seen at this hospital/ED?	How do you receive ADT information from this hospital/ED?
Name of hospital/ED auto-populated (textbox)	○ We do not receive this information ○ At time of event ○ Within 1 day ○ Within 1 week ○ Within 2 weeks ○ More than 2 weeks	○ Practice pulls information: We periodically seek updates from hospital on discharges. ○ Hospital pushes information: Hospital sends a periodic (e.g., daily or weekly) report for all discharged patients. ○ Hospital pushes information: Hospital sends patient-specific alerts to the practice when a hospital discharge occurs.

These questions assess the extent to which your practice communicates and coordinates with hospitals and EDs.

'Patient-specific alerts' are sent in real-time versus periodic reports.

Note: If you select 'We do not receive this information', you will be unable to select any other options.

What communication vehicle do you use to obtain ADT information? (Select all that apply)

- ☐ Phone
- ☐ Fax
- ☐ Email
- ☐ Health Information Exchange (HIE)
- ☐ Access to hospital EHR/hospital portal Access
- ☐ Other: (textbox)

Our method of care coordination…

	Never	Rarely	Some-times	Often	Always
…ensures all practitioners in the practice have access to information about patient care conducted outside of our practice.					
…effectively tracks patients after referral.					
…documents bidirectional communication with practitioners outside of our practice.					

3.2 Care Compacts/Agreements with High Volume Specialists/ Practitioners	Notes
Reporting Periods: Quarterly	
Note: For auditing purposes, you are required to retain a copy of your signed care compacts/collaborative agreements for 10 years per CMS policy.	
Identify the high-volume or high-cost specialists and health care organizations with whom you have formal care compacts/collaborative agreements. (Select all that apply) ☐ We have not established care compacts/collaborative agreements. **Specialists** ☐ Allergy/Infectious disease ☐ Cardiology ☐ Dermatology ☐ Emergency medicine ☐ Endocrinology ☐ ENT/Otolaryngology ☐ Gastroenterology ☐ Hospitalist care ☐ Nephrology ☐ Neurology ☐ Obstetrics/Gynecology ☐ Oncology/Hematology ☐ Ophthalmology ☐ Optometry ☐ Orthopedic surgery ☐ Palliative care ☐ Pain management ☐ Podiatry ☐ Psychiatry ☐ Radiology ☐ Rheumatology ☐ Surgery ☐ Urology **Other Specialty Care** ☐ Behavioral Health ☐ Physical Therapy ☐ Podiatry ☐ Pharmacist ☐ Nutritionist/Dietician services **Other** ☐ Urgent care or after hours care ☐ Home health agency ☐ Other: (textbox)	***Care compacts and collaborative care agreements*** *are established with other practitioners or health care organizations to create formal working relationships and common expectations around roles, flow of information, and shared plans for management.* *For purposes of CPC+, "care compacts" and "collaborative care agreements" are synonymous.* *Note: If you select 'We have not established care compacts/collaborative agreements,' you will be unable to select the other options for this question.*
Please indicate the source(s) of the care compact(s) you use. ☐ American Academy of Pediatrics ☐ American College of Physicians ☐ American Academy of Family Physicians ☐ We use a practice-developed or customized care compact template ☐ Other: (textbox)	*Note: If you select 'We have not established care compacts/collaborative agreements' in the previous question, this question is automatically skipped.*

Reporting Periods: Quarters 2 and 4	
What components are typically included in your care compacts? (Select all that apply) ☐ Sharing data: accurate and up-to-date clinical records ☐ Sharing data: practice-level quality and performance measures ☐ Requirements related to content, timing, and method of communication ☐ Defined responsibilities for patient care and communication throughout the referral process ☐ Defined responsibilities for clinical co-management of specific conditions ☐ Protocols for requesting and conducting referrals ☐ Other: (textbox)	
3.3 Linkages with Social Services **Reporting Periods: Quarters 2 and 4**	**Notes**
What social need domains are **most prevalent** in your patient population? (Select all that apply) ☐ We have not identified prevalent social needs in our population ☐ **Food insecurity:** limited or uncertain access to adequate and nutritious food ☐ **Housing instability**: homelessness, unsafe housing quality, inability to pay mortgage/rent, eviction ☐ **Utility needs:** difficulty paying utility bills, shut off notices, disconnected phone ☐ **Financial resource strain:** inability to pay for basics such as food and medical care ☐ **Transportation:** difficulty accessing/affording transportation (medical or public) ☐ **Employment:** under-employment/unemployment ☐ **Social isolation**: lack of family and/or friend networks, minimal community contacts, absence of social engagement ☐ **Safety:** intimate partner violence, elder abuse, community violence ☐ **Other:** (textbox)	***Prevalent*** *refers to social needs that are frequently reported by your patient population. Only check the social needs that impact a significant portion of your patients.* *Note: If you select 'We have not identified prevalent social needs in our population,' you will be unable to select the other options for this question.*
Do you track demographics from your patients? (e.g., race/ethnicity, educational attainment, family income level, employment status) ○ No ○ Yes, outside of the EHR or health IT platform ○ Yes, in the EHR or other health IT platform	

Do you screen your patients for unmet social needs? ○ We **do not screen** patients for unmet social needs ○ We screen **targeted patients** with high risk that are more likely to suffer from unmet social needs (e.g., depression, hypertension and diabetes) ○ We universally screen **all patients** for unmet social needs	*Note: If you select 'We do not screen patients for unmet social needs,' the next two questions are automatically skipped.*
Which screening tool(s) or question(s) do you use to capture unmet social needs in your patient population? (Select all that apply) We do not regularly use any standard screening tools ☐ HealthLeads screening tool ☐ Institute of Medicine (IOM) recommendations for social and behavioral domains ☐ HealthBegins screening tool ☐ WeCARE screening tool ☐ Accountable Health Communities (AHC) screening tool ☐ Other: (textbox)	*The intent of this question is to understand what screening questions or tools you are using to assess the unmet social needs of your patient population.* *Note: If you select 'We do not screen patients for unmet social needs' in the previous question, this question is automatically skipped.*
Are screening tools integrated with your EHR? ○ Yes ○ No	*Note: If you select 'We do not screen patients for unmet social needs' in the previous question, this question is automatically skipped.*
How frequently is the inventory of social service resources your practice uses updated? ○ We do not maintain or have access to an inventory of these resources ○ Ad hoc basis only ○ At least monthly ○ Every 2-6 months ○ Every 6-12 months ○ Less than annually	*In CPC+, the inventory is a catalog or a listing of social service resources available in your community that your practice uses to meet your patients' social needs. Your practice may create your own or use an existing inventory.* *Note: If you select 'We do not maintain or have access to an inventory of these resources,' you will be unable to select the other options.*
Is the inventory of social service resources integrated with your EHR? ○ Yes ○ No	*Note: If you select 'We do not maintain or have access to an inventory of these resources' in the previous question, this question is automatically skipped.*

How available and accessible are community and government social service resources in your community?

	Unknown	Inadequate	Moderate	Adequate
State programs (e.g., Area Agency on Aging (AAA), Aging and Disability Resource Centers (ADRC))				
Long-term services and supports (for patients needing assistance with daily self-care tasks)				
Home and Community-Based Services (through Medicaid waiver)				
Financial services (e.g., TANF, SSDI/SSI)				
Government nutrition assistance (e.g., SNAP, WIC)				
Information and access services (e.g., 211, eldercare.gov)				
Temporary and permanent housing resources				
Food resources (e.g., food pantries, Meals on Wheels)				
Transportation resources				
Other**:** (textbox)				

The intent of this question is to understand which social service resources are available, and to what extent these services are available in your community, based on information you have gathered or accessed.

***Inadequate** could mean that this resource does not exist at all in your community, or that an organization exists but your patients are unable to access those services for any reason, such as a long waiting list, transportation, financial barriers, etc.*

***Adequate** means that the resource or organization exists in the community, and the services provided are accessible to your patients when they need them.*

Indicate how much you agree or disagree with the following statements.

Our method of coordinating with social services…

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
…integrates with clinical workflow.					
…uses designated staff to coordinate referrals.					
…creates structured referrals.					
…helps patients identify resources in the community.					

3.4 Comprehensiveness	Explanation
Reporting Periods: Quarter 3	
Based on your population needs, identify 1-3 services your practices plans to further develop in the upcoming year. We will ask you the following two questions for each type of service (listed below). **Why are you choosing this service?** (Select all that apply) ☐ Common need in my patient population ☐ Not available for my patients in community ☐ More cost-efficient to deliver this service at the primary care setting (e.g., high-cost referral) ☐ Improve convenience and access for patients ☐ Other: (textbox) **How is the service currently provided?** ○ Referral to specialist ○ Co-management: relationship with a specialist via a care compact ○ Co-location: specialist care at the primary care practice ○ In our practice, by primary care clinicians **List of services:** ○ Behavioral health care ○ Chronic pain management ○ Gynecological services, palliative care ○ Medication therapy management (MTM) ○ Other (textbox)	***Comprehensiveness*** *refers to your practice's ability to meet the majority of your patient population's medical, behavioral, and health-related social needs in pursuit of each patient's health goals.* *In this question, you are sharing information on your practice's initial considerations and decision-making as you begin to enhance comprehensiveness to meet your patients' needs.*

3.5 Behavioral Health Integration

Reporting Periods: Quarters 2 and 4

Notes

Tell us about your behavioral health integration strategies.

☐ We are not integrating behavioral health at our practice.

	Primary Strategy	Secondary Strategy	In planning (not yet implemented)	We use telemedicine to support this strategy
Primary care practitioner delivers behavioral health care				
Specialty referral				
Established care compact/referral agreement				
Co-management between primary care and behavioral health care				
Care Management (proactive, relationship-based care management for mental health condition)				
Primary Care Behaviorist Model (behavioral health professional co-located and integrated into workflow)				

Note: If you select 'We are not integrating behavioral health at our practice,' you will skip the table and move to the next question.

Are behavioral health and medical practitioners involved in care in a standard way across all practitioners and all patients who need behavioral health services?

○ Yes

○ No

Does this type of behavioral health staff support your behavioral health strategy at your practice site?

Staff Type	No	Yes, less than half a day per week	Yes, more than half a day per week
Practitioner (MD/DO/NP/PA)			
Health Educator			
Care Manager (specify)			
Nurse (RN/LPN)			
Psychologist			
Psychiatrist			
Psychiatric NP			
Substance Abuse Counselor			
Social Worker (LCSW)			
Other: (textbox)			

Please list all the staff that support your behavioral health strategy at your practice, even if it is not their primary duty.

What mental health conditions are you targeting with your behavioral health strategy? (Select all that apply)

- ☐ Anxiety Disorders
- ☐ Dementia
- ☐ Depressive Disorders
- ☐ Chronic Pain
- ☐ Complex/chronic disease and comorbidities (e.g., major depressive disorder and poorly controlled diabetes)
- ☐ High risk behaviors (e.g., tobacco use, obesity, and medication adherence)
- ☐ Insomnia
- ☐ Substance Abuse
- ☐ Other: (textbox)

Do you have the following capabilities currently in place to support BHI at your practice?

	Yes	No	In plan-ning	N/A
Screening for behavioral health conditions as standard practice				
Registries and/or EHR functionality to track care of patients with BH conditions				
Ability to monitor and assess treatment response and behavioral health outcomes at your practice (e.g., using validated scales such as PHQ-9)				
Method to share medical records between behavioral health and primary care clinicians				

What payment mechanisms do you use to support behavioral health integration? (Select all that apply)

- ☐ Fee for service (FFS) reimbursement
- ☐ CPC+ care management fee
- ☐ CPC+ CPCP
- ☐ Payer funding specifically for behavioral health services
- ☐ Grant funding
- ☐ Quality incentives or bonus payments from your health system
- ☐ Quality incentives or bonus payments from payers
- ☐ Other: (textbox)

Note: We are asking about all types of payment mechanisms your practice is using to support BHI, not limited to Medicare or CPC+ related funding.

What types of targeted tactics are available for your patients?

	Provided within the practice	Available outside of the practice with external practitioners	Not available or in planning
SBIRT (e.g., alcohol misuse)			
Evidence-based psychotherapy (e.g., CBT, PST)			
Self-management support for behavioral health conditions			
Counseling for behavior change (e.g., smoking cessation, weight loss)			
Other: (textbox)			

***SBIRT** - Screening, Brief Intervention, Referral to Treatment*

***CBT** – Cognitive Behavioral Therapy*

***PST** - Problem-Solving Therapy*

Function 4: Patient and Caregiver Engagement

4.1 Patient and Family Advisory Council (PFAC)	**Notes**
Reporting Periods: Quarterly	
How integrated is the PFAC is at your practice? ○ 1 – PFAC is still in planning or in development ○ 2 ○ 3 – PFAC ideas and recommendations are occasionally integrated into practice improvement processes ○ 4 ○ 5 – PFAC ideas and recommendations are fully integrated into our practice improvement processes	*The intent of this question is to understand where your practice is in the development of PFACs.* *Note: Options '2' and '4' are midpoints on the scale from 1 – 5 for where your practice is in the development of PFACs.*

Which of the following steps has your practice achieved to integrate the PFAC in your practice? (Select all that apply)

- ☐ Identified staff participants
- ☐ Recruited patient participants
- ☐ Defined mission and vision of PFAC
- ☐ Determined structure of PFAC (e.g., number of patients or family advisors, frequency of meetings, term lengths, and other meeting logistics)
- ☐ Developed a sustainability plan for the PFAC
- ☐ We haven't taken any of these steps yet

The steps listed here for PFAC integration are not necessarily sequential.

Identify the number of meetings held by your practice's PFAC in the past quarter: (textbox)

Note: For audit purposes, you are required to retain all meeting minutes for ten years per CMS policy. Track 1 practices are required to convene a PFAC at least once in 2017, and Track 2/CPC Classic practices are required to convene a PFAC in at least two quarters during 2017.

Who typically meets with or is a part of your PFAC?

Role	Number of Individuals
Practitioners (MD/DO, NP, PA)	
Clinical staff (RN, LPN, MA, and care manager)	
Patients and family/caregivers	
Non-clinical staff (e.g., administration, front office, IT)	
Other (textbox)	

The intent of this question is to better understand who is participating in your PFAC. Please estimate the average make-up of your PFAC. Exact numbers are not necessary.

Rate how well your PFAC reflects your practice's overall patient population (i.e., based on factors such as age, gender, race, socioeconomic status, language, or medical conditions)

- ○ Not applicable, or PFAC is still in development
- ○ Not at all representative
- ○ Slightly representative
- ○ Moderately representative
- ○ Very representative
- ○ Completely representative

4.2 Engaging Patients and Caregivers in Your Practice	Notes
Reporting Periods: Quarters 2 and 4	

We engage patients and caregivers as equal partners in…

	Never	Rarely	Some-times	Often	Always
…developing agendas for PFAC meetings.					
…establishing improvement projects.					
…communicating results of improvement projects.					

'Equal partners in care' *refers to the care team actively listening to and involving patients and/or their caregivers/family in setting health goals and making decisions in an environment of mutual respect.*

Besides your PFAC, how do you engage patients and caregivers in practice improvement processes? (Select all that apply)

- ☐ Patient surveys
- ☐ Community meetings
- ☐ Facebook page or other social media site
- ☐ Website/portal
- ☐ Suggestion box
- ☐ Focus groups
- ☐ Other: (textbox)

What areas of practice changes <u>were influenced by patient and caregiver input</u> in the last two quarters? (Select all that apply)

- ☐ We did not implement changes based on patient and caregiver input
- ☐ Governance policies and procedures
- ☐ Patient education and outreach
- ☐ Communication and customer service
- ☐ Patient portal/Patient Health Record changes
- ☐ Practice capabilities to serve unmet medical needs in the population
- ☐ Working with high-risk patients (e.g., risk stratification methodology, care plan development, medication management, self-management support)
- ☐ Patient access and flow (e.g., scheduling, office hours, front office staffing, wait times, forms, etc.)
- ☐ Linkages to community-based social services
- ☐ Coordination with medical neighborhood (e.g., tracking and follow-up from hospital/ED/diagnostic studies, coordination with specialists, etc.)
- ☐ Other: (textbox)

Input includes all forms of patient and caregiver engagement, including PFACs and other strategies.

Note: If you select 'We did not implement changes based on patient and caregiver input,' you will be unable to select the other options for this question.

How did your practice communicate about practice changes to your patients in the last two quarters? (Select all that apply)

- ☐ We did not communicate changes to our patients
- ☐ Materials distributed at the office (e.g., brochures, posters, written notice on visit summary)
- ☐ Materials distributed outside of the office (e.g., newsletters, mailings, social media)
- ☐ Website or patient portal/Patient Health Record
- ☐ Public reporting through local/regional collaboratives or press releases
- ☐ Other: (textbox)

Note: If you select 'We did not communicate changes to our patients,' you will be unable to select the other options for this question.

4.3 Support for Self-Management Across Conditions

Reporting Periods: Quarters 2 and 4

Notes

How frequently does your practice implement each of the following aspects of self-management support to patients and caregivers?

	Never	Rarely	Some-times	Very often	Always
We encourage patients to choose goals that are meaningful to them					
We include family/caregivers in goal-setting and care plan development					
We connect patients and caregivers with self-management support programs that help them maintain wellness at home					
We measure patients' skills and progress (e.g., How's My Health, Patient Activation Measure)					

***Self-management support** refers to help given to people with chronic conditions that enables them to manage their health on a day-to-day basis.*

Which self-management support techniques are staff trained in at your practice? (Select all that apply)

- ☐ Staff are not trained in self-management support techniques
- ☐ Motivational interviewing
- ☐ 5 A's (Ask, Advise, Assess, Assist, Arrange)
- ☐ Teachback
- ☐ Reflective listening
- ☐ Other: (textbox)

If your staff is currently being trained in self-management support techniques, please indicate this as an option. Note: Track 1 practices are required to assess practice capability and plan for support of patients' self-management during 2017.

Note: If you select 'Staff are not trained in self-management support techniques,' you will be unable to select the other options for this question.

4.4 Self-Management Support for Selected Conditions	Notes
Reporting Periods: Quarterly	
For which conditions did your practice provide self-management support in the last quarter? (Select all that apply) ☐ We did not select any conditions for self-management support. <u>Cardiovascular</u> ☐ Congestive Heart Failure (CHF) ☐ Coronary Artery Disease (CAD) ☐ Hyperlipidemia/high cholesterol <u>Respiratory/Pulmonary</u> ☐ Asthma ☐ COPD <u>Mental Health</u> ☐ Depression <u>Substance misuse</u> ☐ Alcohol misuse ☐ Opioid misuse ☐ Tobacco cessation <u>Other</u> ☐ Chronic pain ☐ Hypertension ☐ Diabetes ☐ Obesity/weight Loss ☐ **Other**: (textbox)	*CPC Classic practices and Track 2 practices are required to pick three conditions for self-management support in 2017.* *Note: If you select 'We did not select any conditions for self-management support,' you will be unable to select the other options for this question.*
Reporting Periods: Quarters 1 and 3	
How do you identify patients for self-management support? (Select all that apply) ☐ We do not systematically identify patients for self-management support ☐ All patients with targeted condition ☐ General risk status (using the practice's risk stratification methodology) ☐ Poorly controlled disease ☐ Data from a formal self-management assessment tool ☐ Patient expression of interest ☐ Clinician referral/identification ☐ Other: (textbox)	*Note: If you select 'We do not systematically identify patients for self-management support,' you will be unable to select the other options for this question.*

4.5 Shared Decision Making	Notes
Reporting Periods: Quarter 4	
The intent of this section is to assess the capability of your care teams for shared decision making.	
How do clinicians and staff at your practice involve patients with preference-sensitive conditions in shared-decision making? (Select all that apply) ☐ We do not implement shared decision making for specific conditions ☐ Discuss preferences for care with patients with targeted preference-sensitive conditions ☐ Distribute decision aids to patients with targeted preference-sensitive conditions ☐ Document patients' decisions after shared-decision making For which preference-sensitive health conditions, decisions, or tests of focus is your practice implementing shared decision making? (Select all that apply) ☐ We did not select any preference-sensitive health conditions, decisions, or tests of focus for shared decision making. <u>Therapeutic options in management</u> ☐ Low back pain (acute or chronic) ☐ Insomnia ☐ Chronic pain ☐ Adult sinusitis ☐ Depressive disorders ☐ Osteoarthritis of the hip or knee ☐ Chronic stable angina ☐ Tobacco cessation choices in approach (e.g., classes, medication) ☐ Osteoporosis management and medication choices ☐ Care preferences over the life continuum (e.g., end-of-life decisions and advance care planning) <u>Medication choices</u> ☐ Asthma management ☐ Congestive heart failure management ☐ COPD management ☐ Diabetes management ☐ Anticoagulation for atrial fibrillation ☐ Hypertension management ☐ Statin use ☐ Antibiotic use for acute infections	***Shared decision making*** *is an approach to care that seeks to fully inform patients about the risks and benefits of available treatments for preference-sensitive conditions and engage them as participants in decisions about the treatments.* ***Preference-sensitive conditions*** *are conditions where multiple treatment options exist and there is not consensus supporting a single recommended pathway of care.* ***Decision Aids*** *are tools designed to support patient decision making in preference-sensitive care.* *Note: If you select 'We do not implement shared decision making for specific conditions,' you will be unable to select the other options for this question.*

Screenings ☐ Prostate cancer screening ☐ Mammography for patients age 40 – 49 or over the age of 75 ☐ Lung cancer screening ☐ Colon cancer screening **Other**: (textbox)	
How do you identify patients for shared decision making? (Select all that apply) ☐ We do not systematically identify patients for shared decision making ☐ Ad hoc basis only, no established process or protocol ☐ Clinician or care team referral, based on clinical intuition ☐ Clinician or care team identification, based on routine established protocols ☐ Automatic flags built into EHR or health IT platform ☐ Other: (textbox)	*Note: If you select 'We do not systematically identify patients for shared decision making,' you will be unable to select the other options for this question.*

Function 5: Planned Care and Population Health

5.1 Team-Based Care **Reporting Periods: Quarters 1 and 3**	**Notes**
Please select the member roles found on your typical care team and estimate average number of hours spent by each on a single care team per week.	*The intent of the question is to understand the composition of your care teams. For example, if you have four full-time physicians at your practice in four care teams, the average physician number of hours would be 40 hours. If you have one care manager who splits his or her time between two care teams, then the average number of hours per week would be 20 hours. Approximations are fine.*

Role	Average number of hours per week spent with each care team
Physician	
Nurse Practitioner (NP)	
Physician Assistant (PA)	
Registered Nurse (RN)	
Medical Assistant (MA)	
Licensed Practice Nurse (LPN)	
Care Manager	
Behavioral Health Specialist	
Pharmacist	
Dietician or Nutritionist	
Administrative Staff	
Other: (text box)	

How often are the following clinical activities delegated to members of the care team besides the physician/practitioner (e.g., RN, MAs, front desk staff, other care managers)?

	Never	Rarely	Some-times	Often	Always
Direct patient care activities (e.g., patient education, self-management support activities)					
Patient assessments (e.g., assessing lifestyle factors, screening)					
Communicating with patients (e.g., answering messages from patients)					

What communication structures and processes do care teams use and how often? (Select all that apply)

- ☐ Structured pre-visit huddles
  - ○ Not routinely, or ad hoc
  - ○ Daily
  - ○ Every 1-2 weeks
  - ○ Monthly
  - ○ Other: (textbox)
- ☐ Scheduled care team meetings to discuss high-risk patients and planned care
  - ○ Not routinely, or ad hoc
  - ○ Daily
  - ○ Every 1-2 weeks
  - ○ Monthly
  - ○ Other: (textbox)
- ☐ Other: (textbox)
  - ○ Not routinely, or ad hoc
  - ○ Daily
  - ○ Every 1-2 weeks
  - ○ Monthly
  - ○ Other: (textbox)

Note: When you select 'Structured pre-visit huddles,' 'Scheduled care team meetings,' or 'Other,' you will be prompted to indicate the frequency.

5.2 Use of Data to Plan Care **Reporting Periods: Quarters 2 and 4**	**Notes**
The intent of these questions is to understand how your practice is using your data, and how valuable the data is to your quality improvement work.	
Tell us about how you use data on quality, utilization, patient experience and other measures. We will ask you the following three questions for each type of data (listed below). **At what level is it available?** ○ Not available ○ Practice level ○ Care team or panel level ○ Both the practice and the care team/panel level **How frequently do care teams review this data?** ○ Weekly ○ Monthly ○ Quarterly ○ Annually **How valuable is this data** (list below) **in quality improvement or population health work at your practice?** (Rate from 1-5, with 5 being the most valuable and 1 being not valuable at all) <u>List of data sources:</u> _____ Electronic Clinical Quality Measures (eCQMs); _____ Claims feedback from CMS; _____ Claims feedback from other payers; _____ Patient experience data; Patient; _____ Reported Outcome Measures (PROM); _____ Multi-payer data from health information exchange (HIE), all payer claims databases (APCD), or other data aggregator; _____ Public health data from county or state government; _____ Other: (textbox)	
How does your practice use available data (e.g., quality metrics, utilization data, payer reports) to improve health, increase quality of care, and lower costs for your patient population? ☐ Identify specific patients with gaps in care ☐ Analyze opportunities to reduce cost ☐ Identify services to provide within the practice at lower cost and/or improved quality ☐ Identify opportunities for improvement in existing services. ☐ Identify opportunities to improve value in health care resources the population uses outside of the practice ☐ Other: (textbox)	

5.3 Continuous Quality Improvement **Reporting Periods: Quarters 2 and 4**	Notes
Identify the CPC+ measures on which your practice **focused quality improvement efforts** during the past two quarters. (Select all that apply) eCQMs ☐ Depression Remission at Twelve Months ☐ Controlling High Blood Pressure ☐ Diabetes: Eye Exam ☐ Dementia: Cognitive Assessment ☐ Pneumococcal Vaccination Status for Older Adults ☐ Initiation and Engagement of Alcohol and Other Drug Dependence Treatment ☐ Breast Cancer Screening ☐ Cervical Cancer Screening ☐ Colorectal Cancer Screening ☐ Use of High-Risk Medications in the Elderly ☐ Falls: Screening for Future Falls Risk ☐ Documentation of Current Medications in the Medical Record ☐ Preventive Care and Screening: Screening for Depression and Follow-Up Plan ☐ Diabetes: Hemoglobin HbA1c Poor Control (>9%) ☐ Use of Imaging Studies for Low Back Pain ☐ Closing the Referral Loop: Receipt of Specialist Report ☐ Other: (textbox) Utilization and cost ☐ ED ☐ Inpatient ☐ Specialty care ☐ Imaging/labs ☐ Post-acute care ☐ Other: (textbox) Patient Experience (CAHPS domains) ☐ Getting timely appointments, care, and information ☐ How well practitioners communicate with patients ☐ Overall practitioner ratings ☐ Attention to care from other practitioners ☐ Practitioners support patients in taking care of own health ☐ Other: (textbox)	*Note: Pick at least three quality improvement measures from the nine eCQMs you have selected to report on in your EHR. The intent here is not to choose all of your selected eCQMs, but to tell us you have focused quality improvement efforts on in the last two quarters.*

What quality improvement approach are you using to improve these measures? (Select all that apply)

- ☐ Root cause analysis
- ☐ Plan, Do, Study, Act
- ☐ FADE model
- ☐ Six Sigma
- ☐ Clinical practice improvement method
- ☐ Other: (textbox)

The intent of this question is to learn about the quality improvement approaches your practice uses to improve measures. If your approach is not included on this list, please add or state none.

Why are these measures high priority areas? (Select all that apply)

- ☐ High volume of patients
- ☐ High risk population
- ☐ Poor performance or outcomes
- ☐ High cost or utilization in this area
- ☐ Patient feedback
- ☐ Payment incentive from payers
- ☐ Other: (textbox)

5.4 Culture of Improvement at Your Practice

Reporting Periods: Quarters 2 and 4

Notes

Over the last two quarters, who in your practice…

	Did not occur	Clinical and administrative leadership	Designated quality improve-ment team	Care teams and clinical staff	Non-clinical staff	Patients/ care-givers
…primarily generated improve-ment ideas and opportun-ities?						
…imple-mented improve-ment projects or tests of change?						
…had access to practice-level results?						
…had access to results identified to the applicable practitioner or care team?						

*A **quality improvement team** is a group of people within the practice who meet on a regular basis and are devoted to quality improvement efforts.*

How frequently do care teams at your practice track and measure progress on quality improvement projects?

- ○ We do not routinely track and measure progress on quality improvement projects
- ○ At least weekly
- ○ At least monthly
- ○ At least quarterly
- ○ Only as needed or ad hoc

Note: If you select 'We do not routinely track and measure progress on quality improvement projects,' you will be unable to select the other options for this question.

In thinking about quality improvement activities in your practice, indicate how much you agree or disagree with each statement below.

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Our staff is trained in quality improvement methods.					
We allocate time for **staff** to implement improvement projects or attend practice performance meetings.					
We allocate time for **clinical and administrative leadership** to implement improvement projects or attend practice performance meetings.					
We have open communication and a blame free environment when working on quality improvement.					

General Practice Questions

Reporting Point of Contact **Reporting Periods: Quarterly**	**Notes**
Please provide the name and role of the primary person who completed this reporting. ○ **Name:** (textbox) ○ **Practice role** ○ Practice/office manager or administrator ○ Physician/clinical leader ○ Care manager or clinical staff (RN, LPN, MA) ○ Health system point of contact ○ Other: (textbox)	

CPC+ Payer Partners **Reporting Periods: Quarterly**	**Notes**
Below are the CPC+ payer partners in your region. Please indicate with which payer(s) your practice has a contractual agreement to receive CPC+ payments and other supports for caring for your patients.	*Note: When you are in the practice portal, you will only see payers for your region. Prior responses are shown, and can be updated.*

Patient Demographics **Reporting Periods: Quarter 4**	**Notes**
Tell us about the demographic makeup of your patient population. Please answer these questions to the best of your ability. Percentage of patients of Hispanic, Latino, or Spanish origin (including Mexican, Mexican American, Chicano, Puerto Rican, Cuban, Argentinian, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard, etc.) _____%	*We are asking you to fill this out to update our records to better understand the demographics of CPC+. Exact counts for patient demographics are not necessary. You can use your best estimates for the following questions on patient demographics, if automated data isn't available.*

Percentage of patients by race	**%**
Alaska Native or Native American (*e.g., Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, etc.*)	
Asian *(e.g., Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese, Hmong, Laotian, Thai, Pakistani, Cambodian, etc.)*	
Black or African American (*e.g., African American, Jamaican, Haitian, Nigerian, Ethiopian, Somalian, etc.)*	
Native Hawaiian or other Pacific Islander (*e.g., Samoan, Guamanian or Chamorro, Tongan, Fijian, Marshallese, etc.*)	
White	
Other (textbox)	
Unknown	

Is this based on collected data or best estimate? ○ Collected ○ Best estimate	*Note: This question refers to the previous table on patient demographics.*
Percentage of patients by preferred language: a. English ____% b. Non-English ____% c. If non-English, what is the most common non-English language spoken among your patient population? (textbox)	
Is this based on collected data or best estimate? ○ Collected ○ Best estimate	*Note: This question refers to the previous question on preferred languages.*
Percentage of patients by insurance type: a. Commercial or private __% b. Medicare __% c. Medicare Advantage __% d. Medicaid __% e. Uninsured __% f. Other __%	
Is this based on collected data or best estimate? ○ Collected ○ Best estimate	*Note: This question refers to the previous question on preferred languages.*