Care Delivery Program Requirements

Year 2 - 2018

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Updates

Primary Care Functions

Access and Continuity

- T1 and T2
  - Measure continuity of care for empaneled patients by practitioners and/or care teams in the practice.
- T2 Only
  - **Regularly deliver** care in at least one way that is an alternative to traditional office visit-based care.

Measuring Continuity of Care

- **What?** The continuous relationship between the patient and care team.
- **Why?** Continuity is associated with improved outcomes.
- **How?** Two common methods practices can use to measure continuity are ***patient-centric*** and ***practitioner-centric*** measures

Q1 PY 2	Q2 PY 2	Q3 PY 2	Q4 PY 2
Assess data sources needed to measure continuity of care for empaneled patients by practitioner or care team.	Plan and test measuring continuity of care for empaneled patients.	Measure continuity of care for empaneled patients by practitioner and/or care teams in the practice.	

Measurement Methods

Patient Centric

1. Take the total number of visits to a provider
2. Divide by the total patient visits for empaneled patients

Patient-Centric Continuity Rate

$$= \frac{\text{\# Patient visits with practitioner and/or care team}}{\text{\# Total patient visits for empaneled patients}}$$

Practitioner Centric

- Take the total number of visits to empaneled patients
- Divide by the total number of patient visits to that provider

Practitioner-Centric Continuity Rate

$$= \frac{\text{\# Patient visits to a practitioner by patients empaneled to a practitioner and/or care team}}{\text{\# Total patient visits to that practitioner}}$$

Care Management

- T1 and T2
  - Use a two-step risk stratification process for all empaneled patients, addressing medical need, behavioral diagnoses, and health-related social needs.
  - Based on risk stratification provide longitudinal care management.

- T2 only
  - Based on risk stratification provide longitudinal care management.
  - For patients receiving longitudinal care management, use a plan of care containing **at least** patients' goals, needs and self-management activities that can be routinely accessed and updated by the care team

Comprehensiveness and Coordination

- T1
  - Enact collaborative care agreements with at least two specialists
  - **Develop a plan** for implementation of behavioral health integration based on the two models
- T2 only
  - **Develop a plan** to provide comprehensive medication management to patients discharged from the hospital and those receiving longitudinal care management (ex. Clinical pharmacist)
  - Address psychosocial needs for high risk patients, maintain an inventory of resources, establish relationships with at least two resources
  - Develop practice capabilities to address the needs of a subpopulation of patients with complex needs that improves the quality of care and utilization (ex. Diabetic patients with depression, patients with food shortage issues that have diabetes.)

Patient and Caregiver Engagement

- Track 1
  - Convene a Patient and Family Advisory Council (PFAC) at least **three** times in Program Year 2
  - Implement self-management support for at **least** three high-risk conditions.

- Track 2
  - Convene a PFAC at least quarterly in program year 2
  - Identify and engage a subpopulation of patients and caregivers in **advance care planning**

Advanced Care Planning-Track 2

- **What?** Advance care planning assists patients to make plans about the care they would want to receive if they became unable to speak for themselves.
- **Why?** Early conversations with patients about serious illnesses can improve the quality of care, leading to fewer non-beneficial medical interventions that conflict with patients' goals, and less distress for families

Q1 PY 2	Q2 PY 2	Q3 PY 2	Q4 PY 2
Leverage data sources to identify a subpopulation of patients in need of advance care planning. Create a documentation plan.	Develop and access training for practitioners and/or other practice staff to engage in advance care planning conversations.	Establish a workflow that includes documentation to integrate advance care planning for this subpopulation.	Implement advance care planning for subpopulation of patients in your practice.

New Measures for 2018

CMS ID#	NQF	Measure Title
CMS134v6	0062	Diabetes: medical attention for nephropathy
CMS160v6	0712	Depression utilization of the PHQ-9 tool
CMS147v7	0041	Influenza immunization
CMS127v6	N/A	Pneumoccocal vaccination status for older adults
CMS164v6	0068	IVD: Use of aspirin or another antiplatelet
CMS347v1	N/A	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
CMS2v7	0418	Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Benchmarks TBD

Retired Measures for 2018

CMS ID #	Measure
CMS 156v5	Use of high risk meds in the elderly
CMS 166v6	Use of imaging studies for low back pain
CMS 159v5	Depression Remission at Twelve Months

More Resources on eCQM definitions

https://ecqi.healthit.gov/

Track 1 Action Items

- Establish a method to measure continuity
- Choose a process for two step risk stratification and share with the care team
- Research the two BHI options
- Plan dates for 3 PFACs
- Choose three high risk conditions to focus self-management support
  - Align with eCQMs
- Review 2018 eCQMs and work with vendors to ensure reports are running for 2018
  - **Recommendation: c**hoose one behavioral health measure

Track 2 Action Items

- Establish a method to measure continuity
- Determine what “regularly” means for your practice
- Ensure at least **one** patient goal is capture in care plans
- Begin medication management research (more recommendations for CPC+ to come)
- Plan a method to electronically capture community resources for psychosocial needs (**Health IT requirement**)
- Identify the practices sub-population of high risk patients
  - Align this sub-population to accomplish advanced care planning (**Health IT requirement**)
- Plan dates for **quarterly** PFACs

Resources

Advanced Care Planning

- Serious Illness Conversation Guide
- VitalTalk

Behavioral Health

- CPC+ Connect - Behavioral Health Menu Options.
- AG014: Integrating Behavioral Health Care Management
- AG015:Integrating Behavioral Health Primary Care Behaviorist Model

Social Needs

- AG016: Addressing Social Needs

Care Management

- AG003: Enhanced Longitudinal Care Management

CMS
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CPC+ Connect

Use the search bar to look for resources on CPC+ Connect