

Overview of CPC activity requirements

Requirements

Same-day appointments

- The practice provides same-day access, within 24 hours of initial request, including some weekend hours to a CPC practitioner or a proximate provider with access to patient records who can diagnose and treat

24/7 access to care

- The practice provides and attests to 24 hour, 7 days a week patient access to a primary care physician, primary care physician assistant or a primary care nurse practitioner with access to the patient's medical record

Risk stratification

- Providers use risk stratification from payers in addition to all available clinical and other relevant information to risk stratify all of their patients, and integrates this risk status into records and care plans

Population health management

- Practices identify patients in need of preventative or chronic services and implements an ongoing multifaceted outreach effort to schedule appointments; practice has planned improvement strategy for health outcomes

Team-based care management

- Practice defines care team members, roles, and qualifications; practice provides various care management strategies in partnership with payers and ODM for patients in specific patient segments; practice creates care plans for all high-risk patients, which includes key necessary elements

Follow up after hospital discharge

- Practice has established relationships with all EDs and hospitals from which they frequently get referrals and consistently obtains patient discharge summaries and conducts appropriate follow-up care

Tests and specialist referrals

- The practice has a documented process for tracking referrals and reports, and demonstrates that it:
 - Asks about self-referrals and requests reports from clinicians
 - Tracks lab tests and imaging tests until results are available, flagging and following up on overdue results
 - Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports
 - Tracks fulfillment of pharmacy prescriptions where data is available

Patient experience

- The practice assesses their approach to patient experience and cultural competence at least once annually through quantitative or qualitative means and integrates additional data sources into its assessment where available; information collected by the practice covers access, communication, coordination and whole person care and self-management support; the practice uses the collected information to identify and act on improvement opportunities to improve patient experience and reduce disparities; and practice has process in place to honor relationship continuity through the entire care process

Same day appointments

Provider requirement

Start-up and ongoing:

- The practice provides same day (within 24 hours of initial request) appointments with a practitioner (primary care physician, primary care PA/NP) connected to the CPC practice (i.e. who can access patient records) who can diagnose and treat the patient. This must include some weekend hours that are sufficient to meet patient demand.
- Practice can implement this through arrangements with other proximate providers (primary care physician, primary care PA/NP) who have access to the patients' records (other arrangements may include open scheduling, group visits, and expanded hours)

Acceptable evidence

- Monitoring entity can successfully schedule a same-day appointment in person per specifications above
- Evidence of weekend hours (e.g., weekly schedule)
- Additional evidence deemed reasonable by payer

Payer role

- Validate that the CPC practice offers same day appointments (e.g., extended weekday hours, weekend hours, etc.) in order to ensure accurate information and appropriate guidance is provided by member facing departments to attributed members.

24/7 access to care

Provider requirement

Start-up and ongoing:

- In order to reduce unnecessary use of the emergency room, the practice must provide interactive clinical advice to patients by telephone or secure electronic video conferencing or messaging. A primary care physician, primary care PA/NP who has access to the patient's medical record, by telephone (for urgent requests) or secure electronic communication (for routine requests) must respond to patients seeking clinical advice when the office is both open and closed.
- Practice makes patient clinical information available 24/7 to on-call staff, external facilities, and other clinicians outside the practice when the office is closed through paper or electronic records or telephone consultation
- The CPC practice must provide a response to requests for clinical advice received after hours in accordance with the CPC practice's written policy, and within a reasonable time frame
- All clinical advice is documented in the patient records in accordance with the written policy of the CPC practice not to exceed 1 business day

Acceptable evidence

- Monitoring entity would try to access after-hours advice and confirm that the provider has access to the patients' clinical records, and that they can receive advice by telephone for urgent needs
- Documented process for sharing patient records with relevant parties who work with practice to provide 24/7 access, if relevant
- Office policies for documentation
- Additional evidence deemed reasonable by payer

Payer role

- Validate that the CPC practice offers 24/7 access to care in order to ensure accurate information and appropriate guidance is provided by member facing departments to attributed members.

Risk stratification

Provider requirement

- Start-up: Practice has developed a method for documenting patient risk level that is integrated with overall patient record, and have a clear approach to implement this across their patient panel
- Ongoing:
 - Providers use risk stratification from ODM and contracted MCPs in addition to all available clinical and other relevant information such as cost data or screening results, tobacco use, health risk behaviors to risk stratify all of their patients and communicate this information back to ODM and contracted MCPs as requested
 - Patient risk status is fully integrated into patient records and used to drive decisions around patient treatment, including development of individualized care management plans
 - Providers update their risk stratification periodically (whenever updated information is available from payers or when the practice is informed of a significant change event e.g. hospitalization for the patient) and correspondingly update care plans to reflect changes in risk status

Acceptable evidence

- Care plans for high-risk patients, showing explicitly how risk status was used in their development
- Health records showing risk status incorporated
- List of additional factors considered in supplementing risk stratification information from payers
- Additional evidence deemed reasonable by payer

Payer role

- Generate and provide a list of risk-stratified members attributed to each CPC practice on a regular basis and whenever there is a change in risk status.
- Review the risk stratified list with the CPC practice and provide additional data for high priority patients in order to assist the CPC practice with ongoing care management responsibilities.
- Timely notify the CPC practice of significant change events (IP hospitalizations, ED visits, etc.) that could impact the assigned risk stratification level.
- Update the MCP's care management system to reflect changes to the risk stratification level that are initiated and communicated by the CPC practice.

Population health management

Provider requirement

- Start-up: Practices identify who needs preventative or chronic services and begins outreach to those (either patients or their families/caregivers) who have not been recently seen in order to schedule an appointment or identify additional services to meet the needs of the patient
- Ongoing: All of the above, plus
 - Practices identify patients with gaps in care (e.g., high-risk patient, children who have not had well-checks, and patients who take specific medications), and implement an ongoing multifaceted outreach effort to schedule appointments (independently or through partnership with payers and community)
 - Practices have a planned improvement strategy for health outcomes and business processes; the practice devotes staff resources and time to quality improvement activities with goal of improving health outcomes for the entire patient population
 - Billing process includes appropriate detailed coding for health risk factors (e.g., ICD-10 code z59.0 for lack of housing)

Acceptable evidence

- Practice's overall plan for population health management
- List of conditions that are being tracked
- Methodology for outreach
- Quality improvement strategy
- Workplan outlining payer and provider responsibilities for population health management
- Transition of care plans
- Job descriptions of staff involved in population health and quality improvement
- Additional evidence deemed reasonable by payer

Payer role

- Provide information about MCP-administered specialized services and resources as part of the MCP's model of care for which a CPC practice can refer and link members to with assistance by the MCP.
- Assist with identification of preventive or chronic services that members have not received in order to identify gaps in care.
- Assist in coordinating services as needed (e.g., schedule appointments, arrange transportation, facilitate referrals and linkages to MCP health and wellness programs, etc) in order to assist with improving health outcomes.
- Share timely, meaningful, actionable data with the CPC practice that can facilitate population health activities.

Team-based care management

Provider requirement

- Start-up: Practice has designated and begun to train individual(s) to fill care manager role, which is to help overcome the barriers to the patient getting the evidence-based treatment that they need
- Ongoing: All of the above, plus
 - Practice defines who is on the care team (including the payer(s) and a quality improvement lead as appropriate), care team member qualifications, how team members function in relationship to other providers, ODM and/or contracted MCPs outside the care team; provides orientation and ongoing education and training to staff and holds scheduled patient care team meetings.
 - The practice provides various care management strategies in partnership with ODM and/or contracted MCPs including coordination with practitioners and external care agencies, integration of behavioral health, self-management support for patients with at least three high risk conditions, medication management, and linkage to community-based resources
 - Practice creates care plans for all high-risk patients, which includes key necessary elements, including at minimum patient preferences and functional/lifestyle goals, treatment goals, potential barriers to meeting goals, self-management plan; and is easy to understand and provided in writing to the patient/family/caregiver.
 - The practice identifies and flags key activities that require action/follow-up by ODM and/or the contracted MCP

Acceptable evidence

- Example care plans
- Job descriptions of care team members
- Minutes from care team meetings
- Additional evidence deemed reasonable by payer

Payer role

- Work with each CPC practice to delineate roles and responsibilities for high priority patients to assure there are no gaps in or duplication of services.
- Designate points of contact for each CPC practice to clearly identify who will participate in CPC practice-led patient care team meetings and who will assist the CPC practice with effectively and efficiently navigating MCP processes (e.g., facilitating prior authorizations).
- Participate in CPC practice-led patient care team meetings, when requested.
- Respond timely to requests from the CPC practice for action and follow up by the MCP (e.g., arranging transportation, performing outreach to a patient).
- Receive and integrate critical CPC practice data elements (e.g., social determinants of health identified by the CPC practice) into the MCP's care management system and use the information when interacting with members.
- Share timely, meaningful, actionable data with the CPC practice that can facilitate effective team based care management activities (e.g., resolution of CPC practice requests for MCP follow up).

Follow-up after hospital discharge

Provider requirement

- Start-up: Practice has established relationships with all EDs and hospitals from which they frequently get referrals and has established process to ensure a reliable flow of information
- Ongoing: All of the above, plus
 - Practice proactively and consistently obtains patient discharge summaries from hospitals and other facilities
 - Practice tracks patients receiving care at hospitals and EDs, proactively contacts patients/families for appropriate follow-up care given the cause of admission within an appropriate period following a hospital admission or emergency department visit.
 - Follow-up care may include an in-person visit, physician counseling, referrals to community resources, and disease or case management or self-management support programs

Acceptable evidence

- Evidence of ongoing outreach to/contact with local EDs and hospitals
- Patient discharge summaries, evidence of appointments scheduled or calls made as follow-up, evidence of patient presence on calls or at appointments
- Additional evidence deemed reasonable by payer

Payer role

- Notify the CPC practice of ED visits or IP admissions for high priority patients.
- Participate in discharge planning activities with the CPC practice and inpatient facility in order to support a safe discharge placement and to prevent unplanned or unnecessary readmissions, ED visits, and/or adverse outcomes.
- Support the post discharge services as specified in the discharge/transition plan.
- Facilitate clinical hand offs, upon request from the CPC practice, between the discharging facility and other providers (e.g., home health, community behavioral health agencies).
- Share timely, meaningful, and actionable data with the CPC practice that can facilitate effective care transitions.

Tests and specialist referrals

Provider requirement

- Start-up: Practice has established bidirectional communication with specialists, pharmacies, labs and imaging facilities necessary for referral tracking
- Ongoing: All of the above, plus the practice has a documented process for and demonstrates that it:
 - Asks about self-referrals and requests reports from clinicians
 - Tracks lab tests and imaging tests until results are available
 - Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports
 - Tracks fulfillment of pharmacy prescriptions where data is available

Acceptable evidence

- Contact list for common referrals
- Documented process for referral tracking
- Example referral track for a specific patient
- Additional evidence deemed reasonable by payer

Payer role

- When requested assist with bi-directional communication between the CPC practice and specialists, pharmacies, labs and imaging facilities, as needed, in order to facilitate timely exchange of information.
- Share timely, meaningful, and actionable data with the CPC practice that can facilitate tracking and follow up of tests and referrals (e.g., when patients self-refer).

Patient experience

Provider requirement

- Start-up: The practice has a process to orient all patients to the CPC practice and incorporates patient preference in the primary care provider selection process. The practice builds the continuity of patient relationships through the entire care process.
- Ongoing: All of the above plus
 - The practice assesses their approach to patient experience and cultural competence at least once annually through quantitative or qualitative means (e.g., a patient/family advisory council, focus groups, or a patient survey), and integrates additional data sources into its assessment where available
 - Information collected must cover access, communication, coordination, and whole person care and self-management support
 - The practice uses the information collected to identify improvement opportunities, and take action via concrete initiatives with dedicated staff time to improve overall patient experience and reduce disparities in patient experience

Acceptable evidence

- Results from patient feedback (survey, focus group, advisory council, etc)
- Action plan resulting from patient feedback
- Documented process for patient orientation to CPC practice
- Additional evidence deemed reasonable by payer

Payer role

- Facilitate a warm hand off between the MCP care manager and the CPC practice when care management responsibility transitions from the MCP to the CPC practice.
- Provide quantitative or qualitative data with the CPC practice that can improve the patient experience (e.g., results from the MCP's member advisory groups, member satisfaction surveys, grievances and complaints, member preferences, etc).
- Participate in the CPC practice's improvement opportunities, as requested, that are aimed at improving overall patient experience and reducing disparities in patient experience.