Ohio | Department of Medicaid

CPC and CPC for Kids 2021 Activity Requirements

December 31st, 2020

2021 CPC Activity Requirements

Updated in 2021

Unchanged in 2021

Community services and supports integration	Practice identifies individuals in need of community services and supports and maintains a process to connect attributed individuals to necessary services.
Behavioral health Integration	Practice uses screening tools to identify attributed individuals in need of behavioral health services, tracks and follow up on behavioral health service referrals, and has a planned improvement strategy for behavioral health outcomes.
24/7 and same-day access to care	Practice offers at least one alternative to traditional office visits to increase access to the patient care team and clinicians in ways that best meet the needs of the population. This may include e-visits, phone visits, group visits, home visits, alternate location visits, or expanded hours in the early mornings, evenings, and weekends. Within twenty-four hours of initial request, the practice must provide access to a primary care practitioner with access to the attributed individual's medical record. The practice must also make clinical information of the attributed individual available through paper or electronic records, or telephone consultation to on-call staff, external facilities, and other clinicians outside the practice when the office is closed.
Risk stratification	Practice has a developed method for documenting patient risk level that is integrated within the attributed individual's record and has a clear approach to implement this across the practice's entire patient panel.
Population health management	Practice identifies attributed individuals in need of preventive or chronic services and conducts outreach to schedule applicable appointments or identify additional services to meet the needs of the attributed individual.
Team-based care delivery	Practice defines care team members, roles, and qualifications and provides various care management strategies in partnership with payers, ODM, and other providers as applicable for attributed individuals in specific segments identified by the practice.

2021 CPC Activity Requirements Cont.

Updated in 2021

Unchanged in 2021

Care management plans	Practice creates care plans that include necessary elements for all high-risk attributed individuals as identified by the practice's risk stratification process.
Follow up after hospital discharge	Practice has established relationships with all emergency departments and hospitals from which it frequently receives referrals and has an established process to ensure a reliable flow of information.
Tests and specialist referrals	Practice has established bi-directional communication with specialists, pharmacies, laboratories, and imaging facilities necessary for tracking referrals.
Patient experience	Practice orients all attributed individuals to the practice and incorporates patient preferences in the selection of a primary care provider to build continuity of attributed individual relationships throughout the entire care process; ensures all staff who provide direct care or otherwise interact with attributed individuals complete cultural competency training, as deemed acceptable by ODM, within twelve months of program enrollment and annually thereafter; ensures that new staff who will provide direct care or otherwise interact with attributed individuals completes cultural competency training within ninety days of their start date; routinely assesses demographics and adapts training needs based on demographics; assesses its approach to attributed individual experience and cultural competency at least once annually through the use of the Patient and Family Advisory Council (PFAC) or other quantitative and qualitative means, such as focus groups or a patient survey, that covers access to care, communication, coordination, and whole person care and self-management support; and uses the information to identify and act on opportunities to improve attributed individual experience and reduce cultural disparities, including disparities in the identification, treatment, and outcomes related to chronic conditions such as asthma, diabetes, and cardiovascular health. Practice reports findings and opportunities to attributed individuals, the PFAC, payers, and ODM.

Additional Detail on Activity Metrics in 2021

Activity Requirement	Community Services and Supports Integration
Rule	Practice identifies individuals in need of community services and supports and maintains a process to connect attributed individuals to necessary services.
Provider Criteria for Scoring	• The practice identifies patients in need of community services through utilization of screening tools or other processes to identify health related social needs • The practice uses a systematic approach designed to refer/link patients to necessary community services and supports • The practice has a process to ensure services recommended were received, and has an identified process to close gaps • The practice integrates community services and support activities into broader practice systems, including risk stratification, care management plans and population health management • The practice has a planned improvement strategy for improving outcomes related to community services and supports
Activity Requirement	**Behavioral Health Integration**
Rule	Practice uses screening tools to identify attributed individuals in need of behavioral health services, tracks and follow up on behavioral health service referrals, and has a planned improvement strategy for behavioral health outcomes.
Provider Criteria for Scoring	• The practice identifies patients in need of behavioral health services through regular use of specific tools and processes designed for anticipatory diagnosis • The practice has a systematic approach to timely referral and ongoing follow-up for members with behavioral health needs • The practice validates that services recommended were received with a provision to close gaps in care if necessary • The practice integrates behavioral health activities into broader systems, including care plans, risk stratification, and team-based care delivery • The practice has planned improvement strategy for behavioral health related outcomes

Additional Detail on Activity Metrics in 2021

Activity Requirement	24/7 and same-day access to care
Rule	Practice offers at least one alternative to traditional office visits to increase access to the patient care team and clinicians in ways that best meet the needs of the population. This may include e-visits, phone visits, group visits, home visits, alternate location visits, or expanded hours in the early mornings, evenings, and weekends. Within twenty-four hours of initial request, the practice must provide access to a primary care practitioner with access to the attributed individual's medical record. The practice must also make clinical information of the attributed individual available through paper or electronic records, or telephone consultation to on-call staff, external facilities, and other clinicians outside the practice when the office is closed.

Provider Criteria for Scoring	• Practice provides:
	  • same day appointments
	  • appointments within 24 hours of request
	  • after hours care and weekend hours
	• Practice has interactive clinical advice available 24/7 to patients by telephone, mobile app or secure video messaging
	• The practice has patient clinical information available 24/7 through electronic records or telephone consultation for on-call staff, external facilities, and other clinicians outside of the office when the office is closed

Activity Requirement	**Risk stratification**
Rule	Practice has a developed method for documenting patient risk level that is integrated within the attributed individual's record and has a clear approach to implement this across the practice's entire patient panel.
Provider Criteria for Scoring	• The practice has a stated definition and documented methodology for identifying patient risk tiers, including a high-risk tier • The practice uses risk stratification to assign a risk status for each patient • The practice integrates relevant health risk data into patient records to create individualized care management plans • The practice updates the risk stratification periodically and correspondingly updates care plans to reflect changes in risk status • The practice’s billing process includes appropriate detailed coding for health risk factors, including non-billable codes

Additional Detail on Activity Metrics in 2021

Activity Requirement	Population health management
Rule	Practice identifies attributed individuals in need of preventive or chronic services and conducts outreach to schedule applicable appointments or identify additional services to meet the needs of the attributed individual.
Provider Criteria for Scoring	• The practice identifies patients for preventative or chronic services • The practice performs outreach to patients or family/caregivers for patients who have not been recently seen • The practice identifies patients with gaps in care and implements ongoing multi-faceted outreach efforts to schedule appointments • The practice has a planned improvement strategy for at least one metric related to health outcomes and business processes for population health management

Activity Requirement	Team-based care delivery
Rule	Practice defines care team members, roles, and qualifications and provides various care management strategies in partnership with payers, ODM, and other providers as applicable for attributed individuals in specific segments identified by the practice.
Provider Criteria for Scoring	• The practice has designated and trained individual(s) in the care manager role • The practice incorporates non-traditional workers into the care team • The practice defines who is on the care team • The practice provides various care management strategies in partnership with ODM and/or contracted Managed Care plans

Additional Detail on Activity Metrics in 2021

Activity Requirement	Care management plans
Rule	Practice creates care plans that include necessary elements for all high-risk attributed individuals as identified by the practice's risk stratification process.
Provider Criteria for Scoring	• The practice creates care plans for all high-risk patients identified by the risk stratification system • The practice provides the care plan in writing to the patient/family/caregiver • The practice identifies and flags key activities that require action/follow-up from a care team member

Activity Requirement	Follow up after hospital discharge
Rule	Practice has established relationships with all emergency departments and hospitals from which it frequently receives referrals and has an established process to ensure a reliable flow of information.
Provider Criteria for Scoring	• The practice has established relationships with all EDs and hospitals from which they frequently get referrals • The practice has established processes with the above EDs and hospitals to ensure a reliable flow of information • The practice obtains patient discharge summaries from hospitals and other facilities • The practice connects discharge summary information to risk stratification processes and care management of high-risk patients • The practice tracks patients receiving care at hospitals and EDs • The practice contacts patients/families/caregivers of patients for appropriate follow-up care

Additional Detail on Activity Metrics in 2021

Activity Requirement	Tests and specialist referrals
Rule	Practice has established bi-directional communication with specialists, pharmacies, laboratories, and imaging facilities necessary for tracking referrals.

Provider Criteria for Scoring	• The practice has established bidirectional communication with Specialist, Pharmacies, Labs, and Imaging Facilities for referral tracking
	• The practice has a documented process that includes the following:
	  • 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 follow up on overdue reports
	  • Tracks fulfillment of pharmacy prescriptions

Additional Detail on Activity Metrics in 2021

Activity Requirement	Patient experience
Rule	Practice orients all attributed individuals to the practice and incorporates patient preferences in the selection of a primary care provider to build continuity of attributed individual relationships throughout the entire care process; ensures all staff who provide direct care or otherwise interact with attributed individuals complete cultural competency training, as deemed acceptable by ODM, within twelve months of program enrollment and annually thereafter; ensures that new staff who will provide direct care or otherwise interact with attributed individuals completes cultural competency training within ninety days of their start date; routinely assesses demographics and adapts training needs based on demographics; assesses its approach to attributed individual experience and cultural competency at least once annually through the use of the Patient and Family Advisory Council (PFAC) or other quantitative and qualitative means, such as focus groups or a patient survey, that covers access to care, communication, coordination, and whole person care and self-management support; and uses the information to identify and act on opportunities to improve attributed individual experience and reduce cultural disparities, including disparities in the identification, treatment, and outcomes related to chronic conditions such as asthma, diabetes, and cardiovascular health. Practice reports findings and opportunities to attributed individuals, the PFAC, payers, and ODM.
Provider Criteria for Scoring	• 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 continuity of patient relationships through the entire care process • The practice assesses their approach to patient experience and cultural competence at least once annually using a Patient and Family Advisory Council or by other qualitative means (e.g. focus group, patient survey) and integrates additional data sources into its assessment where available • The practice collects information that covers access, communication, coordination and whole-person care and self-management support • The practice uses collected information to identify improvement opportunities, to help improve patient experiences, and to reduce disparities in patient experience

Additional Detail on Activity Metrics in 2021

Activity Requirement	Patient experience (continued)
Rule	Practice orients all attributed individuals to the practice and incorporates patient preferences in the selection of a primary care provider to build continuity of attributed individual relationships throughout the entire care process; ensures all staff who provide direct care or otherwise interact with attributed individuals complete cultural competency training, as deemed acceptable by ODM, within twelve months of program enrollment and annually thereafter; ensures that new staff who will provide direct care or otherwise interact with attributed individuals completes cultural competency training within ninety days of their start date; routinely assesses demographics and adapts training needs based on demographics; assesses its approach to attributed individual experience and cultural competency at least once annually through the use of the Patient and Family Advisory Council (PFAC) or other quantitative and qualitative means, such as focus groups or a patient survey, that covers access to care, communication, coordination, and whole person care and self-management support; and uses the information to identify and act on opportunities to improve attributed individual experience and reduce cultural disparities, including disparities in the identification, treatment, and outcomes related to chronic conditions such as asthma, diabetes, and cardiovascular health. Practice reports findings and opportunities to attributed individuals, the PFAC, payers, and ODM.
Provider Criteria for Scoring	• The practice has a process to ensure all staff complete cultural competency training within 90 days of their start date and annually thereafter • The practice has a method to assess patient demographics regularly and a strategy to incorporate shifting demographic information into practice processes • The practice has a strategy to address identified health outcome disparities based on patient demographics • The practice has identified a process to share information collected regarding patient experiences with patients, PFACs, ODM, and Managed Care Plans

Additional Detail on CPC Kids Activity Metrics in 2021

CPC Kids Activity	Foster Care Supports
Provider Criteria for Scoring	• The provider can readily identify foster youth (e.g., flag in EHR, registry) • The provider collaborates with local public children services agencies and has special processes or office modifications in place to address foster youth needs • The provider partners with Managed Care Plans (MCPs) to identify foster youth and address their needs

CPC Kids Activity	Behavioral Health
Provider Criteria for Scoring	• The provider is integrated with local behavioral health provider(s) who specializes in pediatrics, which could include physically co-located behavioral health providers within the practice, or a partnership with a behavioral health provider(s) • The provider and behavioral health providers collaborate closely (e.g., through co-location, shared EHR) and have shared responsibility for improved outcomes through individual patient care and practice design • The practice has behavioral health and medical providers that are involved in care in a standard way across all providers and patients

Additional Detail on CPC Kids Activity Metrics in 2021 cont'd.

CPC Kids Activity	School Linkages
Provider Criteria for Scoring	• The provider has a formal partnership with a school or school district to provide care (e.g., primary care, behavioral health care), on or offsite, to students and/or their families • The provider and the school or school district have an established process for student and family referrals • The provider and the school or district agree to bi-directional data sharing that complies with both FERPA and HIPAA guidelines

CPC Kids Activity	Transitions of Care
Provider Criteria for Scoring	• The provider has a process to transition pediatric patients to adult primary care as needed • The provider collaborates closely with new providers during transition (e.g., providing "warm hand offs") and ensures patient care continuity through adulthood, including for special needs patients • The provider ensures that patients do not experience changes in open access to medical records when transitioning to other providers

Additional Detail on CPC Kids Activity Metrics in 2021 cont'd.

CPC Kids Activity	Key Metrics

Provider Criteria for Scoring	• Lead Screening
	  • The practice incorporates lead screening: blood draw is integrated within the primary care visit
	• Social determinants of Health (SDoH):
	  • Upon entry into the practice and annually, provider conducts Adverse Childhood Experiences (ACE) and/or SDoH screening using standardized tools and covering at least 5 domains (e.g., transportation, housing)
	  • Information is used to identify need for referrals to local programs, coordination with school system or address other needs of the child
	• Tobacco cessation
	  • The provider screens adolescent patients for nicotine use and refers or directly cares for patients in need of cessation programs
	• Fluoride
	  • The provider trains practitioners and routinely ensures delivery of fluoride varnishes
	• Breast-feeding support
	  • The provider offers open access to lactation consultant
	  • The provider has a process to discuss breastfeeding benefits, resources and best practices to expectant and new mothers