Primary care a collaborative practice pdf

PCNs are groups of GP practices working closely together - along with other healthcare staff and organisations - providing integrated services to the local population. Since April 2019, individual GP practices have been establishing and joining PCNs covering populations of between 30,000 to 50,000 (with some flexibility). BMA PCN fact sheet ICS (integrated care systems) are a way of planning and organising the delivery of health and care services in England at a larger scale than PCNs. Every ICS will have a critical role in ensuring that PCNs work with other community staff and use multi-disciplinary teams across primary and community care. The BMA PCN handbook provides advice to practices on establishing and running their PCN. This has been updated to include information from the 2021/22 contract agreement, including: updated PCN service specifications and funding streams new ARRS rules and PCN workforce guidance additional operational guidance for PCNs. Download PCN handbook PDF/685KB Download PCN top tips PDF/72KB Since April 2020, auto-enrolment has been included in the DES. This means practices and PCNs do not need to submit anything to their CCG to confirm their acceptance of the revised terms and future years' specifications. If a practice does not want to continue participating in the DES, it must inform its CCG of its decision to opt out within the specified opt out window. Opt-out windows will be open for 30 days whenever revisions are made to the DES specification. Most commonly, these will occur around the time of annual contractual updates in April. However, they may also take place mid-year, if changes to the DES are agreed outside of the annual contract negotiations. NHS England and the BMA have agreed on a data sharing template for use by PCNs. To make things simpler for practices, we have also produced a version of the agreed template which expands on a number of areas with greater detail, along with guidance on the document. These do not constitute legal advice and you should seek professional advice when completing the agreement. When developing a PCN, practices will need to be very careful that the structure they choose does not attract VAT charges. To help guide discussions and future considerations for practices, we have produced two guides on VAT considerations of two of the most common models of PCN; the 'lead practice model' and the 'federation model'. NHS England aim to recruit up to 1,000 link workers by 2021, who will be directly embedded within PCNs. This guidance is to help GPs make the most of the social prescribing schemes they refer patients to and learn how best to work with link workers. There were four additional service specifications due to be introduced in April 2021: personalised care anticipatory care tackling neighbourhood inequalities cardiovascular disease diagnosis. It's been agreed between the BMA and NHS England that they will be delayed, as practices and PCNs prioritise their response to the pandemic and the vaccination programme. Practices will be informed once the service specifications and their date of introduction have been agreed. The four PCN services introduced as part of the DES in 2020 will continue unchanged. These are: extended hours early cancer diagnosis enhanced health in care homes structured medication reviews. View the full service specifications from NHS England. View more on PCN funding. As sole negotiators of the GP contract, the BMA is in a unique position to understand the challenges clinical directors face. We provide a range of expert PCN services and knowledge to support you with running a successful PCN. If you're a clinical director or are involved with the running of your PCN, register your interest to sign up for any of the services or resources below and any in future. Register your interest BMA Law's team of specialist solicitors are on hand to help you navigate the legal process of running a successful PCN. Their solicitors understand that every PCN set-up is unique and all face different legal challenges. To ensure you receive the support you need, they offer a variety of flexible, cost effective service options that are tailored to you; from network agreements to practice premise contracts. Register your interest for more information. The formation of your PCN brings new challenges to ensure you are properly protected. With Lloyd & Whyte, you'll have the cover you need, tailored to your PCN. No two PCNS are the same and the issues you face will vary, which is why Lloyd & Whyte make sure your cover is bespoke to your circumstances. The PCN insurance package can cover: directors and officers insurance (particularly covering clinical directors) employment practice liability (eg claims of unfair dismissal) professional indemnity employer's liability and public liability insurance – to cover any gaps for those working on behalf of the PCN, across practices. Register your interest for more information. We have developed a PCN community app. Register your interest to get access. The latest PCN news, information and guidance at your fingertips. Connect and engage with fellow clinical directors. Leverage the experience of the BMA and PCN community to guide you to PCN success. Start conversations, ask questions and share your experience all in one place. Be the first to know about the latest information and updates from the PCN experts who negotiated the contracts. In early June 2019, we held the first PCN clinical directors conference. The day was attended by over 250 newly appointed clinical directors who received talks from GPC and NHSE negotiators, and workshops from experts covering a variety of topics. Watch the recording Join the BMA We're here to stand up for your rights, support you in the workplace and champion the medical profession. Join us BMA member surveys December 2020 October 2019 Loading... The Comprehensive Primary Care (CPC) initiative is a four-year multi-payer initiative designed to strengthen primary care. Since CPC's launch in October 2012, CMS has collaborated with commercial and State health insurance plans in seven U.S. regions to offer population-based care management fees and shared savings opportunities to participating primary care practices to support the provision of a core set of five "Comprehensive" primary care functions. These five functions are: (1) Risk-stratified Care Management; (2) Access and Continuity; (3) Planned Care for Chronic Conditions and Preventive Care; (4) Patient and Caregiver Engagement; (5) Coordination of Care across the Medical Neighborhood. The initiative is testing whether provision of these functions at each practice site — supported by multi-payer payment reform, the continuous use of data to guide improvement, and meaningful use of health information technology — can achieve improved care, better health for populations, and lower costs, and can inform future Medicare and Medicaid policy. CPC serves as the foundation for Comprehensive Primary Care Plus (CPC+), a five-year advanced primary care medical home model launched in 14 regions in January 2017. CPC+ includes all seven original CPC regions. CPC+ integrates many lessons learned from CPC, including insights on practice readiness, the progression of care delivery redesign, actionable performance-based incentives, necessary health information technology, and claims data sharing with practices. The Participating Practices Select anywhere on the map below to view the interactive version As of October 2016, there are 442 CPC practice sites, distributed across seven CPC regions, based on data from the 16th quarter of CPC. To view an interactive map of this Model, visit the Where Innovation is Happening page, and select this model from the drop-down menu on the left side of the page. In total, 2,188 participating providers are serving approximately 2,700,000 patients, of which approximately 410,177 are Medicare & Medicaid beneficiaries. There are 38 public and private payers participating in the Comprehensive Primary Care initiative. Historically, primary care has been underfunded in the United States. Without a critical mass of payers, investments in primary care made by individual payers—addressing only their respective portion of a practice's patient population—cannot provide sufficient funding for the practice-wide changes needed to transform primary care. CPC is designed to address this impasse through multi-payer collaboration. The seven CPC regions were chosen after soliciting interest from payers nationally. Regions with the highest collective market penetration of payers willing to align their payment models to support the five CPC functions were selected. Eligible practices in each market were invited to apply to participate and start delivering enhanced health care services in the fall of 2012. Practices were selected in mid-2012 through a competitive application process in each selected region based on their use of health information technology, ability to demonstrate recognition of advanced primary care delivery by accreditation bodies, service to patients covered by participating payers, participation in practice transformation and improvement activities, and diversity of geography, practice size and ownership structure. The CPC initiative ended in December 2016. Initiative Details The CPC initiative integrates a defined payment model with a specific practice redesign model to support improved care, better health for populations, and lower health costs through improvement: Payment Model Participating primary care practices receive two forms of financial support on behalf of their fee-for-service (FFS) Medicare beneficiaries: A monthly non-visit based care management fee. The opportunity to share in any net savings to the Medicare program. Read more Participating practices receive a monthly care management fee for each Medicare fee for service (FFS) beneficiary and, in cases where the state Medicaid agency is participating, for each Medicaid FFS beneficiary. The monthly payment from Medicare averages $20 per beneficiary per month during years 1-2 of the initiative (2013-14), and decreases to an average of $15 per beneficiary per month during years 3-4 (2015-16). Practices also receive monthly fees from other participating CPC payers and are expected to combine CPC revenues across payers to develop a whole-practice transformation strategy. Additionally, CMS is offering each CPC practice the opportunity to share net savings generated from improved care to Medicare beneficiaries attributable to the practice. Annually in 2014-16, savings to the Medicare program will be calculated at a regional level and distributed to practices according to their performance on quality metrics. Practices have similar shared savings opportunities with other CPC payers in their region. The other payers in the seven regions encompass public and private payers spanning commercial, Medicare Advantage, Medicaid managed care, and Third Party Administrator/Administrator Services Only lines of business, as well as four state fee-for-service (FFS) Medicaid agencies (Arkansas, Colorado, Ohio, and Oregon). CMS is funding the enhanced payment models offered by state FFS Medicaid agencies. Other CPC payers receive no payment from CMS. Practice Redesign Model CPC provides resources to help practices work with patients to provide the following five comprehensive primary care functions: Access and Continuity: Because health care needs and emergencies are not restricted to office operating hours, primary care practices optimize continuity and timely, 24/7 access to care guided by the medical record. Practices track continuity of care by provider or panel. Planned Care for Chronic Conditions and Preventive Care: Participating primary care practices proactively assess their patients to determine their needs and provide appropriate and timely chronic and preventive care, including medication management and review. Providers develop a personalized plan of care for high-risk patients and use team-based approaches like the integration of behavioral health services into practices to meet patient needs efficiently. Risk-Stratified Care Management: Patients with serious or multiple medical conditions need extra support to ensure they are getting the medical care and/or medications they need. Participating primary care practices empanel and risk stratify their whole practice population, and implement care management for these patients with high needs. Patients and Caregiver Engagement: Primary care practices engage patients and their families in decision-making in all aspects of care, including improvements in the system of care. Practices integrate culturally competent self-management support and the use of decision aids for preference sensitive conditions into usual care. Coordination of Care Across the Medical Neighborhood: Primary care is the first point of contact for many patients, and takes the lead in coordinating care as the center of patients' experiences with medical care. Practices work closely with patients' other health care providers, coordinating and managing care transitions, referrals, and information exchange. Read more CMS guides development of the five CPC functions at each CPC practice through a framework of "Milestones." Participating practices report their Milestone progress regularly through a web portal. CMS supports practices in attaining the CPC Milestones through national and regional learning networks, online collaboration opportunities, and access to local academic and clinical faculty under contract with CMS, who provide hands-on assistance. To support learning across payers, CMS convenes CPC payers on both a regional and national basis to review and discuss data, trends, and strategies for improvement. For more information, please send your questions to CPCi@cms.hhs.gov. Practice Spotlight: Brunswick Family Practice | Troy, NY From the CPC archive: Analysis of the top diagnosis codes in his practice helped James Aram, MD, select radiological screening options for patients with low back pain as a focus for shared decision making in February 2013. This issue was clinically relevant to his patient population, and research clearly showed opportunities to lower costs and reduce unnecessary radiation exposure. After consulting with their EHR vendor to develop the appropriate data collection and reporting functions, Dr. Aram's team developed a video decision aid patients could view before the appointment. Patients can view the video through the patient portal, so that they can share information at home with caregivers or family and offers greater opportunity for the patient's involvement in shared decision making with the practitioner. As of May 2014, practice data show 79 percent of eligible patients had viewed the decision aid, and radiology studies among eligible patients had dropped more than 4 percentage points. In addition to reduced costs associated with fewer radiological studies, no patient adverse events have occurred since implementing this strategy into the practice. Learn more about Brunswick Family Practice's practice transformation (PDF) View a collection of 2015 Practice Spotlights of other CPCI practices (PDF). Evaluations Latest Evaluation Report Prior Evaluation Reports Additional Information

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