Practice Reporting

Practice ID: T1MD0040

Time period: 2019-Q1

Print Date: 03/22/2019 12:56 PM

Function 1

Empanelment

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

Practitioner

Care Team

What is your active beneficiary lookback period?

Less than one year

1-2 years

More than two years

Empanelment Status	Quarter 1
Number of panels at your practice	
Total number of attributed beneficiaries empaneled with a practitioner or care team at your practice	
Total number of attributed beneficiaries at your practice	
% of beneficiaries empaneled	

CTO - Practice Assistance

Did you receive assistance from your partner CTO?

Yes

No

If you would like to provide any additional information regarding the Partner CTO, please do so below (Optional)

Additional Practice Assistance

Did you receive assistance from a state Practice Coach?

Yes

No

If you would like to provide any additional information regarding the state Practice Coach, please do so below (Optional)

[ ]

Did you receive assistance in meeting care transformation requirements from an outside contractor or consultant (this does not include your partner CTO, if associated)?

Yes

No

If you would like to provide any additional information regarding assistance you received from outside contractors or consultants, please do so below (Optional)

[ ]

24/7 Access

Does a clinician or care team member **from your practice site** usually provide 24/7 coverage?

No, we do not 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

Is 24/7 coverage provided **with real-time access** to your practice's EHR?

Yes

No

CTO - Practice Assistance

Did you receive assistance from your partner CTO?

Yes

No

If you would like to provide any additional information regarding the Partner CTO, please do so below (Optional)

[ ]

Additional Practice Assistance

Did you receive assistance from a state Practice Coach?

Yes

No

If you would like to provide any additional information regarding the state Practice Coach, please do so below (Optional)

[ ]

Did you receive assistance in meeting care transformation requirements from an outside contractor or consultant (this does not include your partner CTO, if associated)?

    Yes

    No

If you would like to provide any additional information regarding assistance you received from outside contractors or consultants, please do so below (Optional)

[ ]

Continuity of Care

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

    Yes

    No

CTO - Practice Assistance

Did you receive assistance from your partner CTO?

    Yes

    No

If you would like to provide any additional information regarding the Partner CTO, please do so below (Optional)

[ ]

Additional Practice Assistance

Did you receive assistance from a state Practice Coach?

    Yes

    No

If you would like to provide any additional information regarding the state Practice Coach, please do so below (Optional)

[ ]

Did you receive assistance in meeting care transformation requirements from an outside contractor or consultant (this does not include your partner CTO, if associated)?

    Yes

    No

If you would like to provide any additional information regarding assistance you received from outside contractors or consultants, please do so below (Optional)

[ ]

Enhanced Access and Communication

When beneficiaries need it, my practice is able to provide...

Services	Never	Rarely	Sometimes	Often	Always
... same or next-day appointments					
... office visits on the weekend, evening, or early morning					
... telephone advice on clinical issues during office hours					
... telephone advice on clinical issues on weekends and/or after regular office hours					
... secure/encrypted email or portal advice on clinical issues					

In the last quarter, in which of the following ways did your practice provide alternative approaches to care other than traditional office-based visits? (Select all that apply)

We did not provide alternative approaches to care

Alternative Approaches to Care	How many of your beneficiaries received alternative approaches to care?	For each of the alternative care approaches you selected, who primarily provided this care? (Select all that apply)
Visits in alternative locations (e.g., nursing facilities, hospitals, senior centers)	None Some Most All	MD/DO NP/PA Other, please specify
Home-based care (e.g., primary care home visits)	None Some Most All	MD/DO NP/PA Other, please specify
Medical group visits (e.g., shared medical appointments)	None Some Most All	MD/DO NP/PA Other, please specify
Video-based conferencing (i.e., telehealth or telemedicine)	None Some Most All	MD/DO NP/PA Other, please specify
Medical visit over an electronic exchange (i.e., phone, e-visit or portal)	None Some Most All	MD/DO NP/PA Other, please specify

Alternative Approaches to Care	How many of your beneficiaries received alternative approaches to care?	For each of the alternative care approaches you selected, who primarily provided this care? (Select all that apply)
Other, please specify	None Some Most All	MD/DO NP/PA Other, please specify

CTO - Practice Assistance

Did you receive assistance from your partner CTO?

      Yes

      No

If you would like to provide any additional information regarding the Partner CTO, please do so below (Optional)

Additional Practice Assistance

Did you receive assistance from a state Practice Coach?

      Yes

      No

If you would like to provide any additional information regarding the state Practice Coach, please do so below (Optional)

Did you receive assistance in meeting care transformation requirements from an outside contractor or consultant (this does not include your partner CTO, if associated)?

      Yes

      No

If you would like to provide any additional information regarding assistance you received from outside contractors or consultants, please do so below (Optional)

Function 2
Risk Stratification

Do you risk stratify your empaneled beneficiaries?

    Yes

    No, we do not risk stratify our beneficiaries

What type of risk stratification does your practice use for empaneled beneficiaries?

    Data-driven algorithm only

    Intuition only

    Two-step

    Other, please specify   [   ]

What factors are included in your **data-driven algorithm** for risk stratifying your beneficiaries? (Select all that apply)

    We do not use a data-driven algorithm as part of our risk stratification

    Claims variables

    Clinical variables from the EHR

    Computed risk scores (e.g., CMS-HCC scores or risk scores from other payers)

    Other, please specify   [   ]

What factors do you consider when using **care team/clinical intuition** to stratify your beneficiaries? Do not include factors included in your data-driven algorithm. (Select all that apply)

    We do not use the care team's perception as part of our risk stratification

    Health-Related Social needs

    Behavioral health needs

    Clinical factors

    Other, please specify   [   ]

What prompts reassessment of a beneficiary's risk stratification assignment?

    We do not reassess the risk stratification of our beneficiaries

    Only as needed, or we do not have a protocol in place

    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

Other, please specify [   ]

Is risk stratification integrated within your EHR or health IT system?

Yes

No

CTO - Practice Assistance

Did you receive assistance from your partner CTO?

Yes

No

If you would like to provide any additional information regarding the Partner CTO, please do so below (Optional)

[   ]

Additional Practice Assistance

Did you receive assistance from a state Practice Coach?

Yes

No

If you would like to provide any additional information regarding the state Practice Coach, please do so below (Optional)

[   ]

Did you receive assistance in meeting care transformation requirements from an outside contractor or consultant (this does not include your partner CTO, if associated)?

Yes

No

If you would like to provide any additional information regarding assistance you received from outside contractors or consultants, please do so below (Optional)

[   ]

Identifying Beneficiaries for Care Management

In the table below, please tell us how your beneficiary population is risk stratified and targeted for care management, using your practice's chosen risk stratification method.

Report your beneficiary counts based on a convenient day or moment, as close as possible to the last day of the month.

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

% of Beneficiaries	Quarter 1	Quarter 2	Quarter 3	Quarter 4
% of beneficiaries under care management out of total empaneled				
% of beneficiaries risk stratified out of total empaneled				

How do you identify beneficiaries for episodic care management (short-term goal-directed care management for **beneficiaries not in longitudinal care management**)?(Select all that apply)

We do not identify beneficiaries for episodic care management

Practitioner or care team referral

Hospital admission or discharge

ED visit

Skilled Nursing Facility (SNF) admission or discharge

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, please specify

CTO - Practice Assistance

Did you receive assistance from your partner CTO?

Yes

No

If you would like to provide any additional information regarding the Partner CTO, please do so below (Optional)

[ ]

Additional Practice Assistance

Did you receive assistance from a state Practice Coach?

      Yes

      No

If you would like to provide any additional information regarding the state Practice Coach, please do so below (Optional)

[ ]

Did you receive assistance in meeting care transformation requirements from an outside contractor or consultant (this does not include your partner CTO, if associated)?

      Yes

      No

If you would like to provide any additional information regarding assistance you received from outside contractors or consultants, please do so below (Optional)

[ ]

Care Management Staffing

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 the activities that apply in your practice**)

Activities	None	Practitioner (i.e., MD, DO, NP, PA)	Clinical Staff (e.g., RN, LPN)	Care Manager (e.g., LCSW)	Other, please specify
Developing and monitoring care plans					Other, please specify
Assessing and reassessing beneficiary risk status					Other, please specify
Providing beneficiary education and self-management support					Other, please specify
Routine medication reconciliation at scheduled visits					Other, please specify
Medication reconciliation during transitions of care (hospital, ED discharges)					Other, please specify
Management of care transitions (hospital, ED discharges)					Other, please specify
Coordinating and communicating with specialty care					Other, please specify
Navigating beneficiaries to community and social services					Other, please specify

CTO - Practice Assistance

Did you receive assistance from your partner CTO?

      Yes

      No

If you would like to provide any additional information regarding the Partner CTO, please do so below (Optional)

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Additional Practice Assistance

Did you receive assistance from a state Practice Coach?

       Yes

       No

If you would like to provide any additional information regarding the state Practice Coach, please do so below (Optional)

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Did you receive assistance in meeting care transformation requirements from an outside contractor or consultant (this does not include your partner CTO, if associated)?

       Yes

       No

If you would like to provide any additional information regarding assistance you received from outside contractors or consultants, please do so below (Optional)

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Identifying Hospitals and EDs Your Beneficiaries Use

Identify up to three target hospital(s) and emergency department(s) (EDs) that your beneficiaries **generally** used the most over the last quarter.

Name of Hospital/ED	Hospital only	ED only	Both Hospital and ED

CTO - Practice Assistance

Did you receive assistance from your partner CTO?

       Yes

       No

If you would like to provide any additional information regarding the Partner CTO, please do so below (Optional)

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Additional Practice Assistance

Did you receive assistance from a state Practice Coach?

       Yes

       No

If you would like to provide any additional information regarding the state Practice Coach, please do so below (Optional)

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[                                                                    ]
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Did you receive assistance in meeting care transformation requirements from an outside contractor or consultant (this does not include your partner CTO, if associated)?

Yes

No

If you would like to provide any additional information regarding assistance you received from outside contractors or consultants, please do so below (Optional)

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[                                                                    ]
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Beneficiary Follow-Up - Hospital and ED Discharge

In the table below, provide the counts of your beneficiaries discharged from the emergency department (ED) in the last 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 in 2.5)	Number of beneficiary discharges from this ED	Number of beneficiary 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
Overall discharges and follow-ups				

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

In the table below, provide the counts of your beneficiaries discharged from the hospital in the last 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 (Generated from 2.5)	Number of beneficiary discharges from this hospital	Number of beneficiary 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
Overall discharges and follow-ups				

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

CTO - Practice Assistance

Did you receive assistance from your partner CTO?

Yes

No

If you would like to provide any additional information regarding the Partner CTO, please do so below (Optional)

[   ]

Additional Practice Assistance

Did you receive assistance from a state Practice Coach?

Yes

No

If you would like to provide any additional information regarding the state Practice Coach, please do so below (Optional)

[   ]

Did you receive assistance in meeting care transformation requirements from an outside contractor or consultant (this does not include your partner CTO, if associated)?

Yes

No

If you would like to provide any additional information regarding assistance you received from outside contractors or consultants, please do so below (Optional)

[   ]

Function 3

Coordinated Referral Management with Specialists

Identify the high-volume or high-cost specialists and health care organizations with whom you have coordinated referral management. (Select all that apply)

We have not established coordinated referral management with any of these specialists

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/Psychology

Pulmonology

Radiology

Rheumatology

Surgery

Urology

Other, please specify

CTO - Practice Assistance

Did you receive assistance from your partner CTO?

Yes

No

If you would like to provide any additional information regarding the Partner CTO, please do so below (Optional)

Additional Practice Assistance

Did you receive assistance from a state Practice Coach?

Yes

No

If you would like to provide any additional information regarding the state Practice Coach, please do so below (Optional)

[ ]

Did you receive assistance in meeting care transformation requirements from an outside contractor or consultant (this does not include your partner CTO, if associated)?

      Yes

      No

If you would like to provide any additional information regarding assistance you received from outside contractors or consultants, please do so below (Optional)

[ ]

Identifying and Communicating with Hospitals and EDs Your Beneficiaries Use

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

CTO - Practice Assistance

Did you receive assistance from your partner CTO?

      Yes

      No

If you would like to provide any additional information regarding the Partner CTO, please do so below (Optional)

[ ]

Additional Practice Assistance

Did you receive assistance from a state Practice Coach?

      Yes

      No

If you would like to provide any additional information regarding the state Practice Coach, please do so below (Optional)

[ ]

Did you receive assistance in meeting care transformation requirements from an outside contractor or consultant (this does not include your partner CTO, if associated)?

      Yes

      No

If you would like to provide any additional information regarding assistance you received from outside contractors or consultants, please do so below (Optional)

[   ]

Behavioral Health Integration

What is your practice's primary strategy for addressing behavioral health needs? If you are planning to integrate one of the behavioral health models listed below, please select that option.

- We are not addressing behavioral health needs at our practice

- Behavioral health integration with **Care Management for Mental Illness** (Option 1)

- Behavioral health integration with the **Primary Care Behaviorist model** (Option 2)

- Referrals for external behavioral health specialists

- Other, please specify [   ]

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

- We do not target specific mental health conditions

- Anxiety disorders

- Alzheimer's disease and related dementias

- Depressive disorders

- Complex/chronic disease and comorbidities (e.g., major depressive disorder, poorly controlled diabetes)

- High risk behaviors (e.g., tobacco use, obesity, medication adherence)

- Insomnia

- Substance use disorders

- Other, please specify [   ]

What types of targeted tactics for your beneficiaries are available at your practice? (Select all that apply)

- We do not use any targeted tactics for behavioral health

- Screening for behavioral health conditions as standard practice

- 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, please specify [   ]

CTO - Practice Assistance

Did you receive assistance from your partner CTO?

    Yes

    No

If you would like to provide any additional information regarding the Partner CTO, please do so below (Optional)

Additional Practice Assistance

Did you receive assistance from a state Practice Coach?

    Yes

    No

If you would like to provide any additional information regarding the state Practice Coach, please do so below (Optional)

Did you receive assistance in meeting care transformation requirements from an outside contractor or consultant (this does not include your partner CTO, if associated)?

    Yes

    No

If you would like to provide any additional information regarding assistance you received from outside contractors or consultants, please do so below (Optional)

Linkages with Social Services

Do you routinely screen your beneficiaries for unmet social needs?

    We **do not screen** beneficiaries for unmet social needs

    We screen a **targeted subpopulation of beneficiaries** for unmet social needs

    We universally screen **all beneficiaries** for unmet social needs

What type of screening tool(s) do you use or adapt to capture unmet social needs in your beneficiary population? (Select all that apply)

    We do not use any screening tools

    We use the Accountable Health Communities (AHC) tool only

    Other Standardized screening tool (e.g., screening tools published by HealthLeads, IOM/NAM)

    Tool developed by practice or system

Other, please specify

[   ]

Are screening tools or questions integrated with your EHR or health IT system?

    Yes

    No

What are the health-related social needs your practice has prioritized to address in your beneficiary population? (Select all that apply)

    We have not prioritized any social needs to address in our beneficiary 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, medical care, insurance, and medication costs

    Transportation : Difficulty accessing/affording transportation (i.e., 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, please specify

[   ]

CTO - Practice Assistance

Did you receive assistance from your partner CTO?

    Yes

    No

If you would like to provide any additional information regarding the Partner CTO, please do so below (Optional)

[   ]

Additional Practice Assistance

Did you receive assistance from a state Practice Coach?

    Yes

    No

If you would like to provide any additional information regarding the state Practice Coach, please do so below (Optional)

[   ]

Did you receive assistance in meeting care transformation requirements from an outside contractor or consultant (this does not include your partner CTO, if associated)?

Yes

No

If you would like to provide any additional information regarding assistance you received from outside contractors or consultants, please do so below (Optional)

[   ]

Coordinating with Social Service Resources

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

Do you have an inventory of social service resources integrated with your EHR?

Yes

No

Identify the social service resources and supports with whom you have established relationships to address the prioritized areas you selected above. (Select all that apply)

We have not established relationships with social service resources and supports

Financial (e.g., TANF, SSDI/SSI, cash assistance)

Nutrition and food (e.g., SNAP/WIC, food pantries, Meals on Wheels)

Health-related services (e.g., insurance, prescription assistance, home health, durable medical equipment)

Housing (e.g., shelter, public housing, transitional support)

Transportation (e.g., medical transport, public transit)

Utilities (e.g., energy assistance/subsidies [LIHEAP], telephone)

Other, please specify   [   ]

CTO - Practice Assistance

Did you receive assistance from your partner CTO?

Yes

No

If you would like to provide any additional information regarding the Partner CTO, please do so below (Optional)

Additional Practice Assistance

Did you receive assistance from a state Practice Coach?

Yes

No

If you would like to provide any additional information regarding the state Practice Coach, please do so below (Optional)

Did you receive assistance in meeting care transformation requirements from an outside contractor or consultant (this does not include your partner CTO, if associated)?

Yes

No

If you would like to provide any additional information regarding assistance you received from outside contractors or consultants, please do so below (Optional)

Function 4

Engaging Beneficiaries and Caregivers in Your Practice

Tell us how frequently your practice engages beneficiaries and caregivers in...

Activities	Never	Rarely	Sometimes	Often	Always
...developing agendas for Patient and Family Advisory Council (PFAC) meetings					
...establishing improvement projects					
...communicating results of improvement projects					

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

We have not taken any of these steps

Identified staff participants

Recruited beneficiary participants

Defined mission and vision of PFAC

Determined structure of the PFAC (e.g., number of beneficiaries or family advisors, frequency of meetings, term lengths, and other meeting logistics)

Incorporated PFAC recommendations into practice

Communicated PFAC recommendations to beneficiaries and staff

Developed a sustainability plan for the PFAC

Identify the number of meetings held by your practice's PFAC in the last quarter

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

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

Is the PFAC representative of your practice's overall beneficiary population in the following ways?

Not applicable, or PFAC is still in development

Not at all representative

Age

Race

Socio-economic status

Language spoken

CTO - Practice Assistance

Did you receive assistance from your partner CTO?

Yes

No

If you would like to provide any additional information regarding the Partner CTO, please do so below (Optional)

[ ]

Additional Practice Assistance

Did you receive assistance from a state Practice Coach?

Yes

No

If you would like to provide any additional information regarding the state Practice Coach, please do so below (Optional)

[ ]

Did you receive assistance in meeting care transformation requirements from an outside contractor or consultant (this does not include your partner CTO, if associated)?

Yes

No

If you would like to provide any additional information regarding assistance you received from outside contractors or consultants, please do so below (Optional)

[ ]

Self-Management Support for Selected Conditions

For which conditions did your practice provide condition-specific support for self-management in the last quarter? (Select all that apply)

We do not offer self-management support for any conditions

Cardiovascular

Congestive Heart Failure (CHF)

Coronary Artery Disease (CAD)

Hyperlipidemia/high cholesterol

Hypertension

Respiratory/Pulmonary

Asthma

COPD

Mental Health

Anxiety

Depression

Substance Disorder

Alcohol misuse

Tobacco cessation

Opioid misuse

Other

Chronic pain

Diabetes

Obesity/weight loss

Other, please specify

How do you identify beneficiaries for self-management support? (Select all that apply)

We do not systematically identify beneficiaries for self-management support

All beneficiaries with targeted condition

General risk status (using the practice's risk stratification methodology)

Poorly controlled disease

Data from a formal self-management assessment tool

Beneficiary expression of interest

Clinician referral/identification

Other, please specify

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

Activities	Never	Rarely	Sometimes	Very Often	Always
We encourage beneficiaries to choose goals that are meaningful to them					
We include family/caregivers in goal-setting and care plan development					
We connect or provide beneficiaries and caregivers with formal self-management support services at our practice or in the community					
We measure beneficiary’s skills and progress (e.g., How's My Health, Patient Activation Measure [PAM])					
Our staff are trained in specific self-management support techniques (e.g., motivational interviewing, 5 A's, Teach Back, reflective listening)					

CTO - Practice Assistance

Did you receive assistance from your partner CTO?

Yes

No

If you would like to provide any additional information regarding the Partner CTO, please do so below (Optional)

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Additional Practice Assistance

Did you receive assistance from a state Practice Coach?

      Yes

      No

If you would like to provide any additional information regarding the state Practice Coach, please do so below (Optional)

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Did you receive assistance in meeting care transformation requirements from an outside contractor or consultant (this does not include your partner CTO, if associated)?

      Yes

      No

If you would like to provide any additional information regarding assistance you received from outside contractors or consultants, please do so below (Optional)

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└─────────────────────────────┘
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Function 5

Team-Based Care

How often do care teams at your practice have structured huddles focused on beneficiary care?

      Never

      Only as needed or ad hoc

      At least daily

      At least weekly

      At least every 2 weeks

      At least monthly

How often do care teams at your practice have scheduled care team meetings to discuss high-risk beneficiaries and planned care?

      Never

      Only as needed or ad hoc

      At least daily

      At least weekly

      At least every 2 weeks

At least monthly

How often are the following clinical activities delegated to members of the care team (e.g., RN, MA, front desk, or other practice staff) other than the practitioner?

Activities	Never	Rarely	Sometimes	Often	Always
Direct beneficiary care activities (e.g., beneficiary education, self-management support activities)					
Beneficiary assessments (e.g., assessing lifestyle factors, screening)					
Communicating with beneficiaries (e.g., answering messages from beneficiaries)					

How often do care teams at your practice meet and review quality improvement data (e.g., data on quality, cost, utilization, and beneficiary experience of care)?

Never

Only as needed or ad hoc

At least weekly

At least monthly

At least quarterly

At least annually

CTO - Practice Assistance

Did you receive assistance from your partner CTO?

Yes

No

If you would like to provide any additional information regarding the Partner CTO, please do so below (Optional)

Additional Practice Assistance

Did you receive assistance from a state Practice Coach?

     Yes

     No

If you would like to provide any additional information regarding the state Practice Coach, please do so below (Optional)

Did you receive assistance in meeting care transformation requirements from an outside contractor or consultant (this does not include your partner CTO, if associated)?

     Yes

     No

If you would like to provide any additional information regarding assistance you received from outside contractors or consultants, please do so below (Optional)

General

General Information

MDPCP Program Questions

Tell us how useful your practice finds each type of communication for MDPCP information and updates. (Rate from 1-5, with 5 being very useful and 1 being not useful at all) (Optional)

Communication Type	Rating
MDPCP biweekly newsletter	
MDPCP Connect (social media platform)	
Practice Facilitator and/or learning network email	
MDPCP Support	
Learning sessions, Action Groups, Practices in Action, and webinars	
Other, please specify	

Please estimate the number of hours your practice spent collecting and inputting data for your care transformation information this quarter. Please round to the nearest whole hour increment. (Optional)

Practice Information Verification

I have reviewed my practice's demographic, organization details and composition information. I certify that it is accurate to the best of my knowledge.

Reporting Point of Contact

Are you the primary contact for Practice Reporting for this Quarter?

Yes

No

Confirmation

I have reviewed the information above and certify that it is accurate to the best of my knowledge.

First Name

Last Name

Position with MDPCP Practice Site

System Generated Date