Practice Reporting

Practice ID: T1MD9008

Time Period: 2021-Q1

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Function 1

Empanelment

Do you primarily 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	As of close of Quarter 1
Number of panels at your practice	
Total number of beneficiaries empaneled with a practitioner or care team at your practice	
Total number of beneficiaries at your practice	
% of beneficiaries empaneled	

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

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

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 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	Which beneficiaries receive the alternative care approaches noted below?
☐ Visits in alternative locations (e.g., nursing facilities, hospitals, senior centers)	☐ Available to all beneficiaries ☐ Targeting high risk beneficiaries only ☐ Other, please specify
☐ Home-based care (e.g., primary care home visits)	☐ Available to all beneficiaries ☐ Targeting high risk beneficiaries only ☐ Other, please specify
☐ Medical group visits (e.g., shared medical appointments)	☐ Available to all beneficiaries ☐ Targeting high risk beneficiaries only ☐ Other, please specify
☐ Medical visit via video-based conferencing (e.g., via patient portal or other secure platform)	☐ Available to all beneficiaries ☐ Targeting high risk beneficiaries only ☐ Other, please specify
☐ Other, please specify	☐ Available to all beneficiaries ☐ Targeting high risk beneficiaries only ☐ Other, please specify

Function 2

Risk Stratification

Do you risk stratify your empaneled beneficiaries?

☐ Yes

☐ No

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)

☐ Pre-AH Tool (Likelihood for Avoidable Hospital Events report)

☐ Other, please specify

What prompts reassessment of a beneficiary's risk stratification assignment? (Select all that apply)

☐ 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

Identifying Beneficiaries for Care Management

In the table below, please tell us how your beneficiary population is risk stratified and targeted for care management, whether longitudinal or episodic. Report your beneficiary counts based on a convenient day or moment, as close as possible to the last day of the past quarter.

Level of Risk (highest risk at the top)	Total number of beneficiaries in this tier	Number of beneficiaries in this tier under care management	% of total empaneled beneficiaries in this risk tier	% of beneficiaries in this risk tier under care management
Not assigned				
Total empaneled beneficiaries				

% of Beneficiaries	As of the close of Q1
% of beneficiaries under care management out of total empaneled	
% of beneficiaries risk stratified out of total empaneled	

Indicate how you identify beneficiaries for episodic/short-term, goal-directed care management (for those **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

Care Management Staffing

Please indicate the staff at your practice who support MDPCP, not including providers listed on your practice's Practitioner Roster.

Title/Position	Approximate FTEs Supporting MDPCP
Behavioral Health Specialist	
Social Worker	
Care Manager/Care Coordinator	
Community Health Worker (CHW)	
Consultant	
Dietitian/Nutritionist	
Health Educator	
Laboratory/Radiology Technician	
Licensed Practical Nurse (LPN)	
Medical Assistant	
Pharmacist/Pharmacy Technician	
Physical/Respiratory Therapist	
Practice Supervisor/Practice Manager	
Quality Improvement Specialist	
Receptionist/Appointing	
Registered Nurse (RN)	
Other Health Staff, please specify	
Total	

Does your practice have a designated lead care manager either employed by you or your CTO for MDPCP?

- ☐ Yes
- ☐ No

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

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

Which of the following self-management support activities does your practice use? (Select all that apply)

- ☐ We do not use self-management support activities
- ☐ 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 beneficiaries' skills and progress (e.g., How's Your Health, Patient Activation Measure [PAM])
- ☐ Staff are trained in self-management support techniques (e.g., motivational interviewing, 5 As)

Care Plans

Among beneficiaries under longitudinal care management, how many have a care plan?

- ☐ None (0%)
- ☐ Some (Up to 50%)
- ☐ Most (51-95%)
- ☐ All (96-100%)

Do you document and store care plans?

- ☐ No
- ☐ Yes, care plans are **integrated** with the EHR or other health IT
- ☐ Yes, care plans are documented and stored, but are **not integrated** with the EHR or other health IT

Who has real-time/point-of-care access to a beneficiary’s care plan? (Select all that apply)

- ☐ Members of the care team within the practice
- ☐ Clinicians outside of the practice (i.e., other specialists who care for the beneficiary)
- ☐ Community and/or social service agencies and practitioners
- ☐ Beneficiary and his/her caregiver(s)

☐ Other, please specify

Beneficiary Follow Up - Hospital and Emergency Department

Does your practice track your beneficiaries' emergency department (ED) discharges?

☐ Yes

☐ No

Does your practice track your beneficiaries' hospital discharges?

☐ Yes

☐ No

Comprehensive Medication Management

Which of the following steps has your practice achieved to implement comprehensive medication management (CMM)? (Select all that apply)

☐ We have not taken any of these steps yet

☐ Established a plan for identifying beneficiaries with CMM needs

☐ Identified and/or hired personnel for CMM

☐ Trained staff as necessary

☐ Developed workflows and processes

In the last two quarters, has your practice provided comprehensive medication management to beneficiaries?

☐ No, we are not implementing comprehensive medication management

☐ No, we are in the process of developing a plan for comprehensive medication management

☐ No, we have established a plan for comprehensive medication management, but have not yet implemented it

☐ Yes, we provided comprehensive medication management support

Who primarily provides comprehensive medication management for your beneficiaries?

☐ Pharmacist

☐ Primary care practitioners at our practice (MD/DO, NP/PA)

☐ Care Manager

☐ Other, please specify

How does your practice deliver comprehensive medication management?

☐ Coordination with an **external** pharmacist, program, or service

- ☐ Co-management with a pharmacist, program, or service **located at our practice**
- ☐ **Primary care practitioners** from our practice primarily deliver comprehensive medication management

How do you identify beneficiaries for comprehensive medication management? (Select all that apply)

- ☐ Recent discharge from the hospital
- ☐ Beneficiaries who are receiving longitudinal care management
- ☐ Recent visit to ED
- ☐ Active medication issues (e.g., adverse reactions, adherence, not reaching intended treatment outcomes)
- ☐ Potential therapy issues (e.g., high risk medications, poly-pharmacy, multi-therapy drug interactions, high cost medications)
- ☐ Referred by practitioner or care team
- ☐ Other, please specify

Function 3

Coordinated Referral Management with Specialists

Identify high-frequency referral and/or high-cost specialty care providers with whom you have coordinated referral management. (Select all that apply)

- ☐ We do not have 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
- ☐ Pain management
- ☐ Palliative care
- ☐ Podiatry
- ☐ Psychiatry/Psychology
- ☐ Pulmonology
- ☐ Radiology
- ☐ Rheumatology
- ☐ Surgery
- ☐ Urology
- ☐ Other, please specify

Describe your coordinated referral management system

Identifying and Communicating with Hospitals and EDs Your Beneficiaries Use

Tell us how you coordinate and communicate about admission/discharge/transfer (ADT) information with hospitals and EDs, such as through CRISP services including Care Alerts or Encounter Notification Service (ENS)

On average, how promptly do you access ADT information about your beneficiaries seen at a hospital/ED?	**Is ADT information access integrated within your EHR or HIT System?**
☐ We do not have access to ADT information from hospitals/EDs ☐ At time of event ☐ Daily ☐ Within 1 week ☐ Within 2 weeks ☐ Over 2 weeks	☐ Yes ☐ No

Behavioral Health Integration

What strategies does your practice address behavioral health needs? (Select all that apply)

- ☐ We do not address behavioral health needs at our practice
- ☐ Behavioral health integration with the **Collaborative Care model** , also called **Care Management for Mental Illness**
- ☐ Behavioral health integration with the **Primary Care Bahaviorist model**
- ☐ Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- ☐ Referrals for external behavioral health specialists
- ☐ Other, please specify

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

- ☐ We do not target specific behavioral health conditions
- ☐ Anxiety disorders
- ☐ Alzheimer's disease and related dementias
- ☐ Depressive disorders
- ☐ Chronic pain
- ☐ 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) and Substance Use Disorder (SUD)
- ☐ 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

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 adopt to capture unmet social needs in your beneficiary population? (Select all that apply)

☐ We do not use any screening tools

☐ Accountable Health Communities (AHC) tool

☐ 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

Health-Related Social Needs	Do you have an established, ongoing relationship with social resources to address this need?
☐ Food insecurity	☐ Yes ☐ No
☐ Housing instability	☐ Yes ☐ No
☐ Utility needs	☐ Yes ☐ No
☐ Financial resource strain	☐ Yes ☐ No
☐ Transportation	☐ Yes ☐ No
☐ Employment	☐ Yes ☐ No
☐ Social isolation	☐ Yes ☐ No
☐ Safety	☐ Yes ☐ No
☐ Other, please specify	☐ Yes ☐ No

Do you have an inventory of social service resources?

☐ Yes

- ☐ No

How frequently is the inventory of social service resources your practice uses updated?

- ☐ Ad hoc basis only
- ☐ At least monthly
- ☐ Every 2-6 months
- ☐ Every 6-12 months
- ☐ Less than annually

Describe any barriers to prioritizing health-related social needs. (Optional)

Function 4

Engaging Beneficiaries and Caregivers in Your Practice

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)
- ☐ Established meetings at an interval determined by the practice
- ☐ Held a PFAC meeting in the last 12 months
- ☐ Established improvement projects
- ☐ Incorporated beneficiary and/or caregiver feedback into PFAC agendas or improvement projects
- ☐ Incorporated PFAC recommendations into practice
- ☐ Communicated PFAC recommendations to beneficiaries and staff
- ☐ Developed a sustainability plan for the PFAC

Who typically meets with or is a part of your PFAC? (Select all that apply)

- ☐ 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

Advance Care Planning

Who at your practice is/are typically involved in advance care planning? (Select all that apply)

- ☐ We do not provide advance care planning
- ☐ Practitioners (MD/DO, NP, PA)
- ☐ Other clinical staff (RN, LPN, MA, care manager)
- ☐ Other, please specify

How does your practice identify beneficiaries for advance care planning? (Select all that apply)

- ☐ We do not systematically identify beneficiaries for advance care planning
- ☐ High-risk status (using the practice's two-step risk stratification methodology)
- ☐ Beneficiaries with serious illness and/or based on age (e.g., cancer diagnosis, end-stage kidney disease, heart failure, COPD)
- ☐ Clinician or care team referral/identification
- ☐ Other, please specify

As part of advance care planning, do clinicians and staff ... (Select all that apply)

- ☐ Address the beneficiary's values, goals, or care preferences at the end of life
- ☐ Assist beneficiaries in understanding and completing relevant documents (e.g., advanced directives, POLST/MOLST forms, health care power of attorney)
- ☐ Determine beneficiary designation of health care surrogate or proxy
- ☐ Promote communication between beneficiaries and health care proxy regarding the beneficiary's values/goals/care preferences at the end of life
- ☐ Other, please specify

What system(s) do you use to document and store advance care planning conversations and decisions? (Select all that apply)

- ☐ We do not document and store advance care planning conversations and decisions

- ☐ EHR or other health IT
- ☐ A local or regional Health Information Exchange
- ☐ MyDirectives (https://mydirectives.com) or similar site/platform
- ☐ Patient portal/patient health record
- ☐ Other, please specify

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 do care teams at your practice meet and review quality improvement data (e.g., data on quality measures, 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

Use of Data to Plan Care

Tell us about how you use data on quality, utilization, beneficiary experience, and other measures.

Data Type	At what level is this data available?	How frequently do care teams review this data?
Electronic clinical quality measures (eCQMs)	☐ Not available ☐ Practice level ☐ Care team or panel level ☐ Both the practice and the care team/panel level	☐ We do not regularly review this data ☐ At least weekly ☐ At least monthly ☐ At least quarterly ☐ At least annually ☐ Other, please specify
Claims data feedback from CMS	☐ Not available ☐ Practice level ☐ Care team or panel level ☐ Both the practice and the care team/panel level	☐ We do not regularly review this data ☐ At least weekly ☐ At least monthly ☐ At least quarterly ☐ At least annually ☐ Other, please specify
Claims data feedback from other payers	☐ Not available ☐ Practice level ☐ Care team or panel level ☐ Both the practice and the care team/panel level	☐ We do not regularly review this data ☐ At least weekly ☐ At least monthly ☐ At least quarterly ☐ At least annually ☐ Other, please specify

Data Type	At what level is this data available?	How frequently do care teams review this data?
Beneficiary experience data	☐ Not available ☐ Practice level ☐ Care team or panel level ☐ Both the practice and the care team/panel level	☐ We do not regularly review this data ☐ At least weekly ☐ At least monthly ☐ At least quarterly ☐ At least annually ☐ Other, please specify
Patient-Reported Outcome Measures (PROMs)	☐ Not available ☐ Practice level ☐ Care team or panel level ☐ Both the practice and the care team/panel level	☐ We do not regularly review this data ☐ At least weekly ☐ At least monthly ☐ At least quarterly ☐ At least annually ☐ Other, please specify
Multi-payer data from Health Information Exchange (HIE), all payer claims databases (APCD), or other data aggregator	☐ Not available ☐ Practice level ☐ Care team or panel level ☐ Both the practice and the care team/panel level	☐ We do not regularly review this data ☐ At least weekly ☐ At least monthly ☐ At least quarterly ☐ At least annually ☐ Other, please specify

Data Type	At what level is this data available?	How frequently do care teams review this data?
Public health data from county or state government	☐ Not available ☐ Practice level ☐ Care team or panel level ☐ Both the practice and the care team/panel level	☐ We do not regularly review this data ☐ At least weekly ☐ At least monthly ☐ At least quarterly ☐ At least annually ☐ Other, please specify
Internal practice or system data	☐ Not available ☐ Practice level ☐ Care team or panel level ☐ Both the practice and the care team/panel level	☐ We do not regularly review this data ☐ At least weekly ☐ At least monthly ☐ At least quarterly ☐ At least annually ☐ Other, please specify
Other, please specify	☐ Not available ☐ Practice level ☐ Care team or panel level ☐ Both the practice and the care team/panel level	☐ We do not regularly review this data ☐ At least weekly ☐ At least monthly ☐ At least quarterly ☐ At least annually ☐ Other, please specify

Continuous Quality Improvement

Identify the measures on which your practice **focused its quality improvement efforts** during the past two quarters. (Select all that apply)

- ☐ We have not focused quality improvement efforts on any of the measures below

eCQMs

- ☐ Controlling High Blood Pressure (MDPCP measure)
- ☐ Diabetes: Hemoglobin HbA1c Poor Control (>9%) (MDPCP measure)
- ☐ Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (MDPCP Measure)
- ☐ Preventive Care and Screening: Screening for Depression and Follow-Up Plan (MDPCP Measure)
- ☐ Diabetes: Eye Exam
- ☐ Diabetes: Medical Attention for Nephropathy
- ☐ Dementia: Cognitive Assessment
- ☐ Preventive Care and Screening: Screening for Depression and Follow-Up Plan
- ☐ Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- ☐ Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- ☐ Falls: Screening for Future Falls Risk
- ☐ Breast Cancer Screening
- ☐ Cervical Cancer Screening
- ☐ Colorectal Cancer Screening
- ☐ Preventive Care and Screening: Influenza Immunization
- ☐ Pneumococcal Vaccination Status for Older Adults
- ☐ Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet
- ☐ Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
- ☐ Closing the Referral Loop: Receipt of Specialist Report
- ☐ Other, please specify

Utilization and Cost

- ☐ ED
- ☐ Inpatient
- ☐ Specialty care

- ☐ Imaging/labs
- ☐ Post-acute care
- ☐ Observation stays
- ☐ Other, please specify

Patient Experience (as measured by CAHPS or other tool)

- ☐ Getting timely appointments, care, and information
- ☐ How well practitioners communicate with patients
- ☐ Overall practitioner ratings
- ☐ Attention to care from other practitioners
- ☐ Practitioners support beneficiaries in taking care of own health
- ☐ Other, please specify

Why are these measures high-priority areas? (Select all that apply)

- ☐ High volume of beneficiaries
- ☐ High-risk population
- ☐ Poor performance or outcomes
- ☐ High cost or utilization in this area
- ☐ Beneficiary feedback
- ☐ Payment incentive from payers
- ☐ Other, please specify

Culture of Improvement at Your Practice

Over the last two quarters, who in your practice. . . (Select all that apply)

Activities	Did not occur	Clinical and administrative leadership	Designated quality improvement team	Care teams and clinical staff	Non-clinical staff	Beneficiaries/ caregivers
...primarily generated improvement ideas and opportunities?	☐	☐	☐	☐	☐	☐
...implemented improvement projects or tests of change?	☐	☐	☐	☐	☐	☐
...had access to practice-level results?	☐	☐	☐	☐	☐	☐
...had access to results identified to the applicable practitioner or care team?	☐	☐	☐	☐	☐	☐

General

Practice Assistance Information

Please select all the areas in which you received assistance:

Note: CTO Assistance can include CTO Practitioner (i.e., MD, DO, NP, PA), CTO Clinical Staff (i.e., RN, LPN), CTO Care Manager (i.e., LCSW) and/or Other CTO Support.

Care Delivery Transformation Area	CTO Assistance	Practice Coach Assistance (Optional)	Outside Contractor or Consultant (non-CTO)(Optional)
1.1 Empanelment	☐ Not Received ☐ CTO Practitioner ☐ CTO Clinical Staff ☐ CTO Care Manager ☐ Other, please specify	☐	☐
1.2 24/7 Access	☐ Not Received ☐ CTO Practitioner ☐ CTO Clinical Staff ☐ CTO Care Manager ☐ Other, please specify	☐	☐
1.3 Continuity of Care	☐ Not Received ☐ CTO Practitioner ☐ CTO Clinical Staff ☐ CTO Care Manager ☐ Other, please specify	☐	☐
1.4 Enhanced Access and Communication	☐ Not Received ☐ CTO Practitioner ☐ CTO Clinical Staff ☐ CTO Care Manager ☐ Other, please specify	☐	☐

Care Delivery Transformation Area	CTO Assistance	Practice Coach Assistance (Optional)	Outside Contractor or Consultant (non-CTO)(Optional)
2.1 Risk Stratification	☐ Not Received ☐ CTO Practitioner ☐ CTO Clinical Staff ☐ CTO Care Manager ☐ Other, please specify	☐	☐
2.2 Identifying Beneficiaries for Care Management	☐ Not Received ☐ CTO Practitioner ☐ CTO Clinical Staff ☐ CTO Care Manager ☐ Other, please specify	☐	☐
2.3 Care Management Staffing	☐ Not Received ☐ CTO Practitioner ☐ CTO Clinical Staff ☐ CTO Care Manager ☐ Other, please specify	☐	☐
2.4 Care Plans	☐ Not Received ☐ CTO Practitioner ☐ CTO Clinical Staff ☐ CTO Care Manager ☐ Other, please specify	☐	☐

Care Delivery Transformation Area	CTO Assistance	Practice Coach Assistance (Optional)	Outside Contractor or Consultant (non-CTO)(Optional)
2.5 Beneficiary Follow Up - Hospital and Emergency Department	☐ Not Received ☐ CTO Practitioner ☐ CTO Clinical Staff ☐ CTO Care Manager ☐ Other, please specify	☐	☐
2.6 Comprehensive Medication Management	☐ Not Received ☐ CTO Practitioner ☐ CTO Clinical Staff ☐ CTO Care Manager ☐ Other, please specify	☐	☐
3.1 Coordinated Referral Management with Specialists	☐ Not Received ☐ CTO Practitioner ☐ CTO Clinical Staff ☐ CTO Care Manager ☐ Other, please specify	☐	☐
3.2 Identifying & Comm w/Hospitals & EDs	☐ Not Received ☐ CTO Practitioner ☐ CTO Clinical Staff ☐ CTO Care Manager ☐ Other, please specify	☐	☐

Care Delivery Transformation Area	CTO Assistance	Practice Coach Assistance (Optional)	Outside Contractor or Consultant (non-CTO)(Optional)
3.3 Behavioral Health Integration	☐ Not Received ☐ CTO Practitioner ☐ CTO Clinical Staff ☐ CTO Care Manager ☐ Other, please specify	☐	☐
3.4 Linkages with Social Services	☐ Not Received ☐ CTO Practitioner ☐ CTO Clinical Staff ☐ CTO Care Manager ☐ Other, please specify	☐	☐
4.1 Engaging Beneficiaries and Caregivers in Your Practice	☐ Not Received ☐ CTO Practitioner ☐ CTO Clinical Staff ☐ CTO Care Manager ☐ Other, please specify	☐	☐
4.2 Advance Care Planning	☐ Not Received ☐ CTO Practitioner ☐ CTO Clinical Staff ☐ CTO Care Manager ☐ Other, please specify	☐	☐

Care Delivery Transformation Area	CTO Assistance	Practice Coach Assistance (Optional)	Outside Contractor or Consultant (non-CTO)(Optional)
5.1 Team-Based Care	☐ Not Received ☐ CTO Practitioner ☐ CTO Clinical Staff ☐ CTO Care Manager ☐ Other, please specify	☐	☐
5.2 Use of Data to Plan Care	☐ Not Received ☐ CTO Practitioner ☐ CTO Clinical Staff ☐ CTO Care Manager ☐ Other, please specify	☐	☐
5.3 Continuous Quality Improvement	☐ Not Received ☐ CTO Practitioner ☐ CTO Clinical Staff ☐ CTO Care Manager ☐ Other, please specify	☐	☐
5.4 Culture of Improvement at Your Practice	☐ Not Received ☐ CTO Practitioner ☐ CTO Clinical Staff ☐ CTO Care Manager ☐ Other, please specify	☐	☐

Please provide any additional details or feedback about the assistance you have received or indicate the areas in which you are interested in future assistance (Optional)

Practice General Information

MDPCP Track and CRISP Information

Please indicate how your practice uses CRISP in the table below.

Does your practice, including in partnership with your CTO	**Response**
Submit Care Alerts to CRISP for your attributed beneficiaries?	☐ Yes ☐ No
Update your ENS panel and have submitted to CRISP within the last 90 days?	☐ Yes ☐ No
Review the Pre-AH avoidable hospital events tool and follow up with your high-risk beneficiaries on a monthly basis?	☐ Yes ☐ No

Patient Demographics

Tell us about the demographic makeup of your patients population. Please answer these questions to the best of your ability.

Percentage of patients by preferred language	**%**
English	
Non-English	
Total	

Is this based on collected data or best estimate?

- ☐ Collected
- ☐ Best estimate

Percentage of patients by primary insurance type	%
Commercial or private	
Medicare Fee-for-Service	
Medicare Advantage	
Medicaid	
Uninsured	
Other, please specify	
Total	

Is this report based on collected data or best estimate?

- ☐ Collected
- ☐ Best estimate

MDPCP Program Questions

Which types of information and updates are useful for your practice? (Select all that apply) (Optional)

- ☐ MDPCP monthly newsletter
- ☐ MDPCP Connect (resources, (e.g., program guides and recorded webinars); networking and discussion with other MDPCP participants)
- ☐ PMO and Practice Coaches
- ☐ PMO weekly eBlasts
- ☐ MDPCP PMO staff and provider training sessions
- ☐ MDPCP Help Desk (MarylandModel@cms.hhs.gov)
- ☐ Affinity Groups
- ☐ Other, please specify

Please provide your feedback on the above items

How would you rate the level of effort required to complete this quarter's reporting?

- ☐ Low level of effort
- ☐ Appropriate level of effort

☐ High level of effort

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.

EIDM User Name

Position with MDPCP Practice Site

System Generated Date