Primary care transformation occurred in 441 practices across the 7 CPC regions
(number of participating practices in bold)

The CPC Community*

<table>
<thead>
<tr>
<th>Medicare FFS beneficiaries</th>
<th>Medicaid FFS beneficiaries</th>
<th>Commercially insured patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>327,000</td>
<td>79,000</td>
<td>Over 800,000</td>
</tr>
</tbody>
</table>

*All numbers are approximate

Supporting Patients with CPC

2.8 million patients received care at CPC practices. CPC payers supported over 40% of all patients.

Proportion of Attributed CPC Patients Supported by Payer Type

Care Management Fee Contribution by Payer Type, 2015

3% Medicaid
37% Medicare
60% Commercial

$3.3 million
$44 million
$57 million

KEY

Medicaid
Medicare
Commercial Payers

Practice self-reported budgeting and progress on the five comprehensive primary care functions, which guide practice transformation, as of July 2016. These five functions are: Risk-stratified Care Management, Access and Continuity, Planned Care for Chronic Conditions and Preventive Care, Patient and Caregiver Engagement, and Coordination of Care across the Medical Neighborhood. These figures do not represent an evaluation of this work or CPC itself.
Increasing the Depth and Breadth of Care Management

424 (96%) of practices implemented care plans for patients under care

- Treatment goals identified by the patient and care team (89%)
- Patient's plans for self-management (84%)
- Patient's plans for acute changes in condition (60%)

99% of all active patients were empaneled to a provider or care team

94% of empaneled patients were risk-stratified (increased by 3% from 2015)

20% of empaneled patients were under care management

Serving a Diverse Patient Population

Increased Patient Access

- 99% Expanded availability of same or next day appointments
- 68% Adopted a flexible appointment scheduling system
- 64% Extended hours into mornings, evenings, and weekends

Helped Patients Manage Chronic Diseases in Their Daily Lives

- 91% Included family/caregivers in goal-setting and plan development
- 81% Conducted between-visit coaching
- 59% Documented patients' confidence areas and potential barriers

Engaging Staff and Caregivers to Create a Culture of Improvement

Patient Engagement Strategy

- 20% Practice-based survey
- 27% Patient Family Advisory Council
- 50% Both

Quality Improvement Activities

- 99% of practices regularly used data on utilization, cost, and patient experience
- 91% of practices integrated quality improvement into staff duties
- 80% of practices allocated time for staff to implement quality improvement

1 Empanelment assigns patients to a practitioner or care team, as a foundation for population health management and relationships with patients.
2 Risk-stratification means that a practice assigns risk statuses to all of its patients to help proactively identify patients with high needs.
3 Care management is a primary care function tailored to patients at highest risk for adverse, preventable outcomes.

Practice self-reported budgeting and progress on the five comprehensive primary care functions, which guide practice transformation, as of July 2016. These five functions are: Risk-stratified Care Management, Access and Continuity, Planned Care for Chronic Conditions and Preventive Care, Patient and Caregiver Engagement, and Coordination of Care across the Medical Neighborhood. These figures do not represent an evaluation of this work or CPC itself.