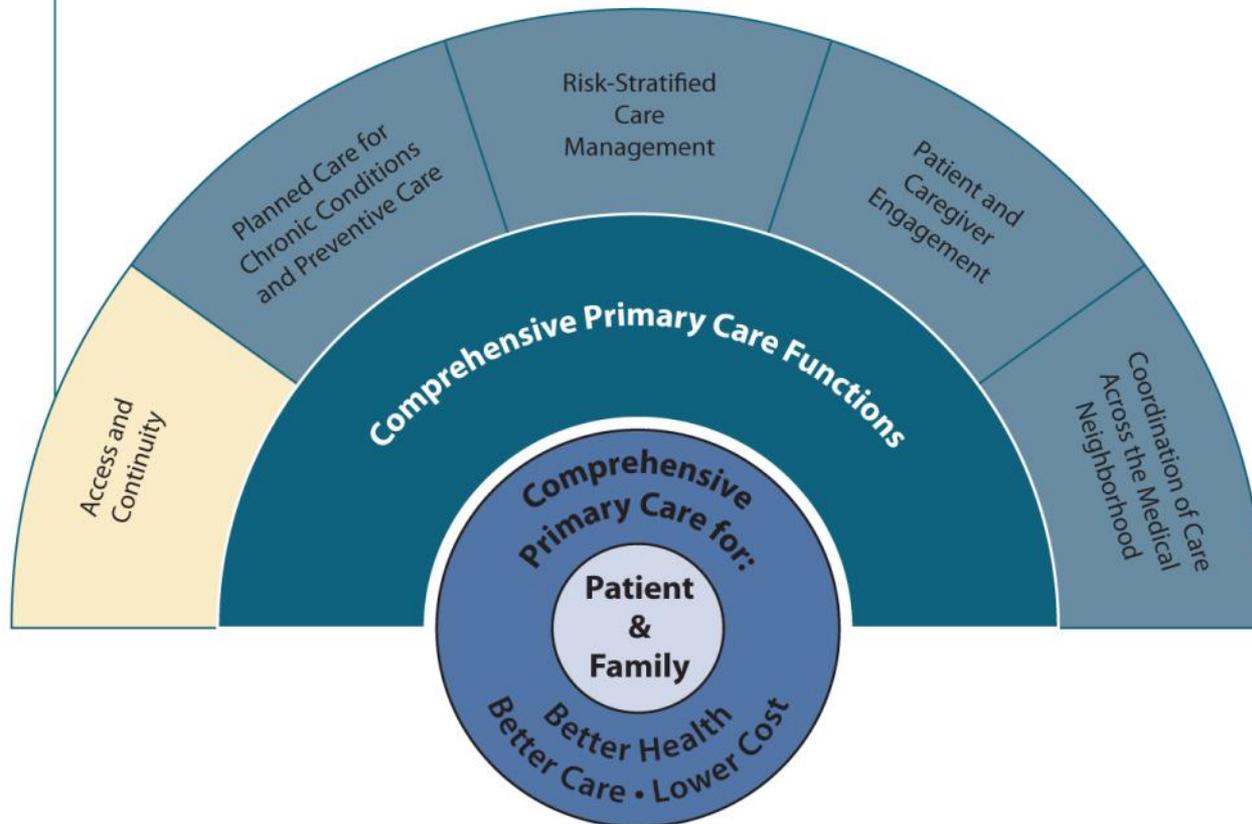


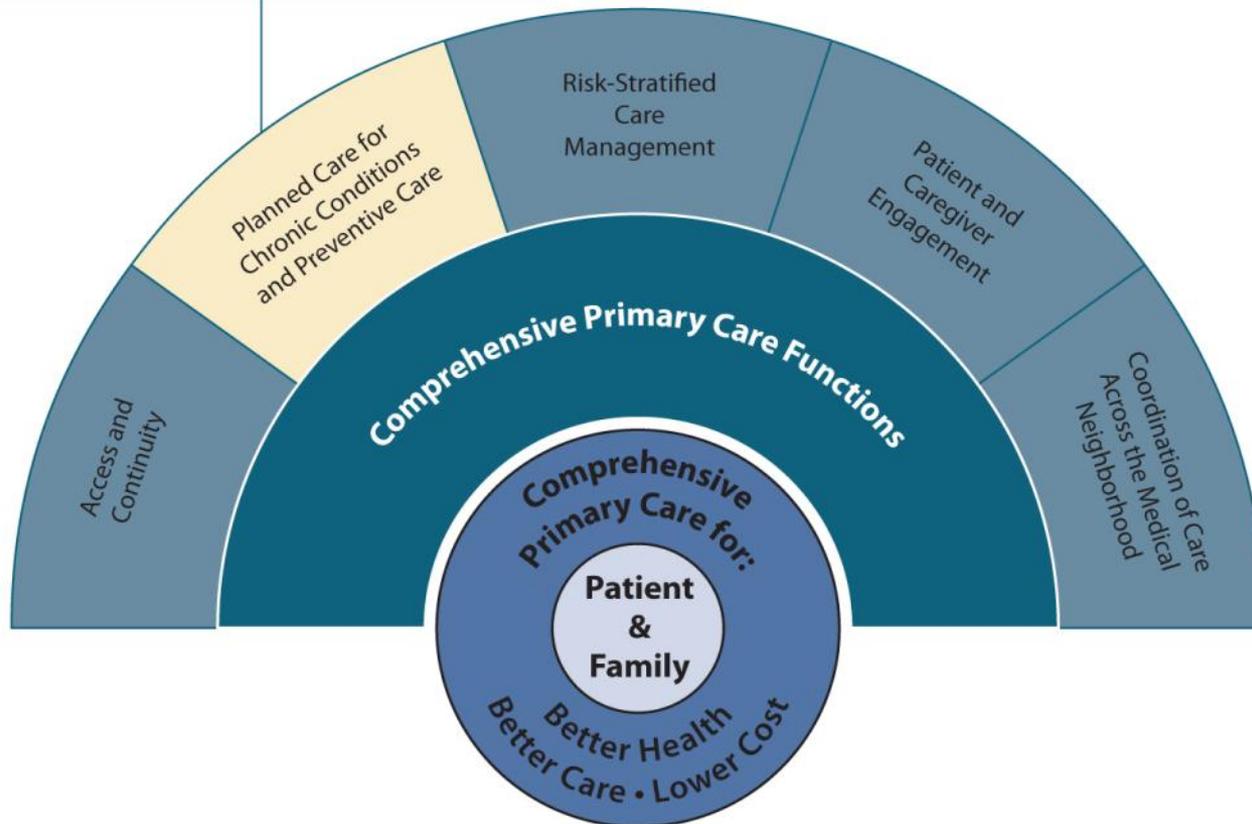
### Change Concept

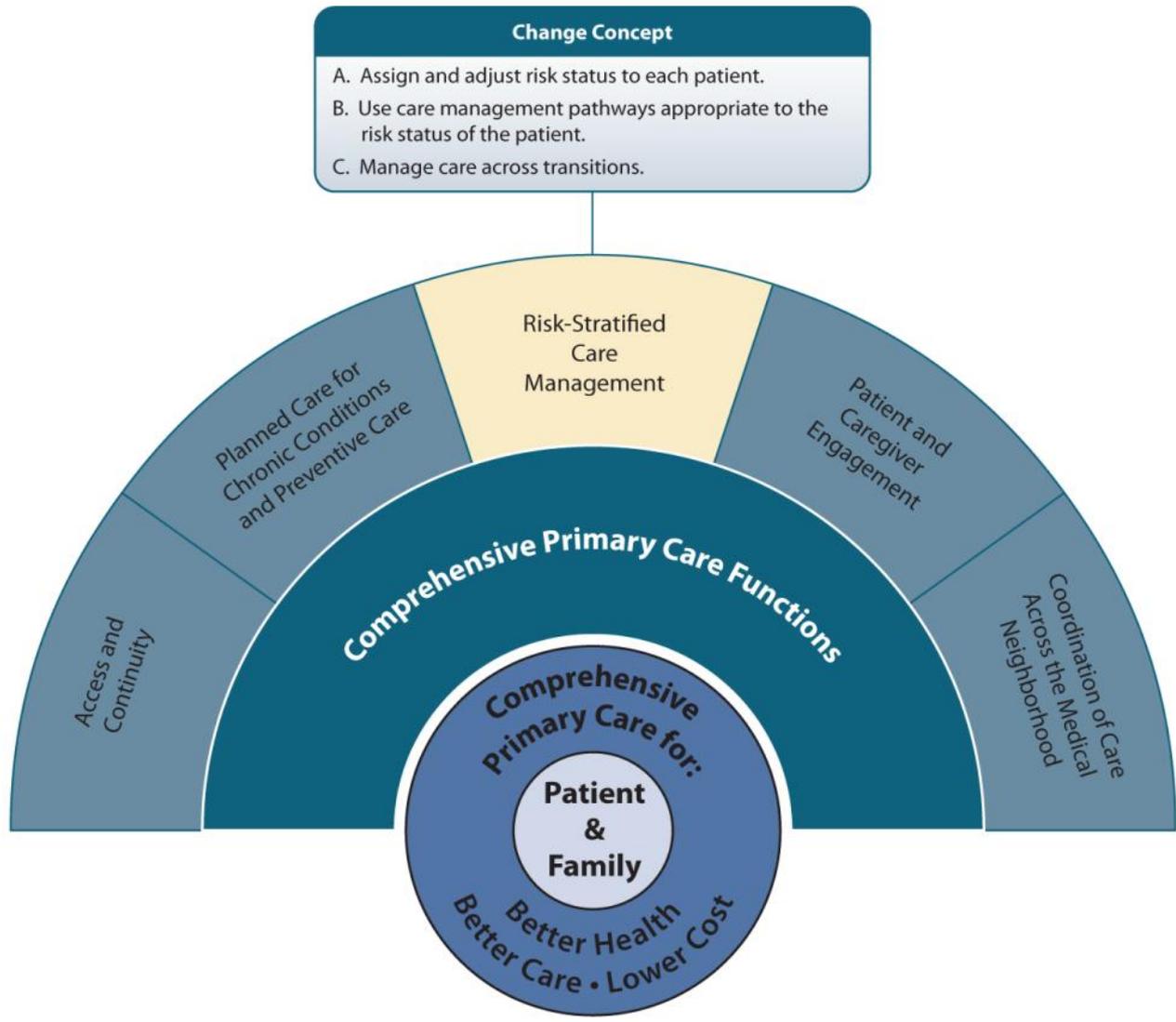
- A. Optimize timely access to care guided by the medical record.
- B. Empanel all patients to a care team or provider.
- C. Optimize continuity with provider and care team.

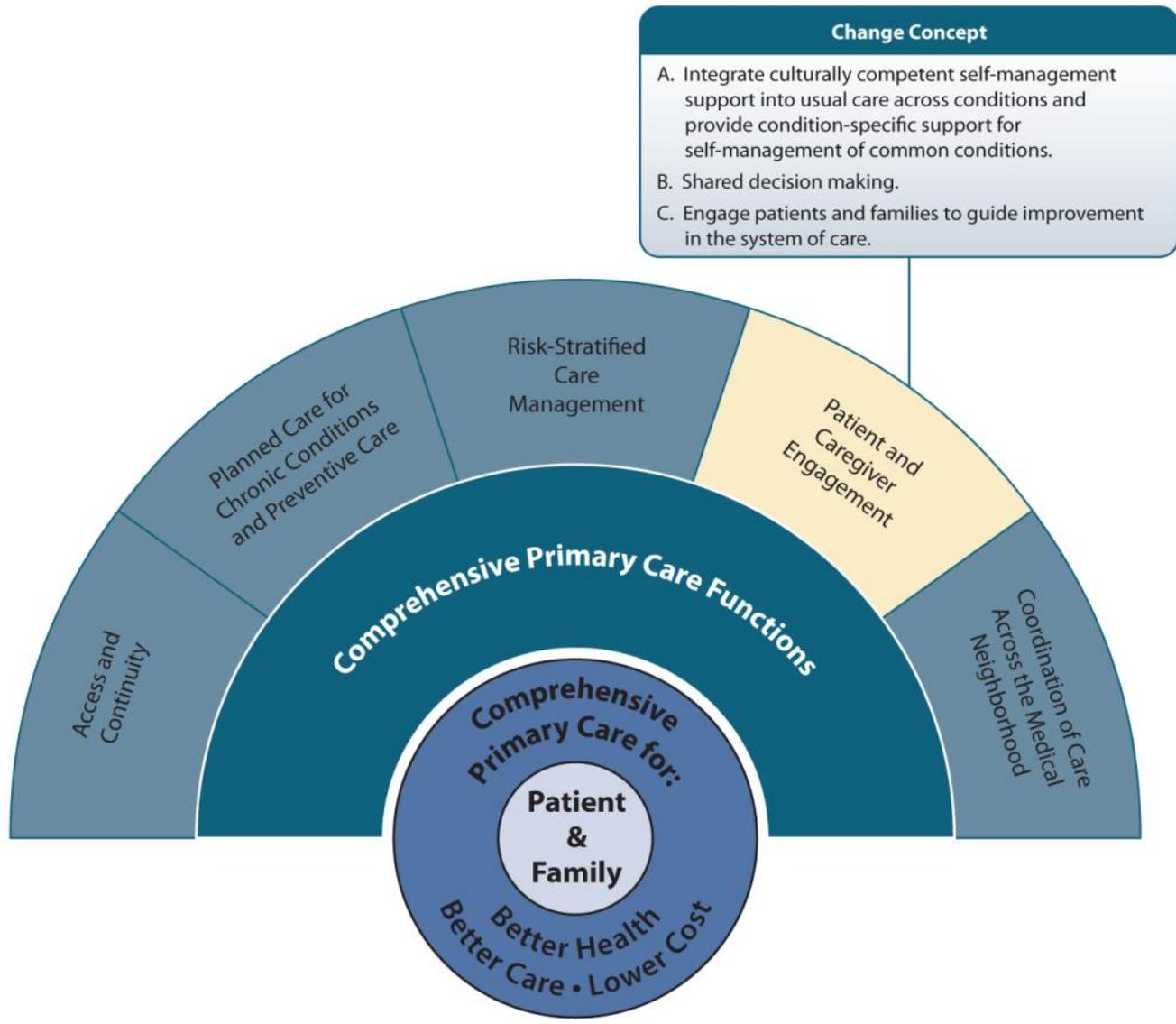


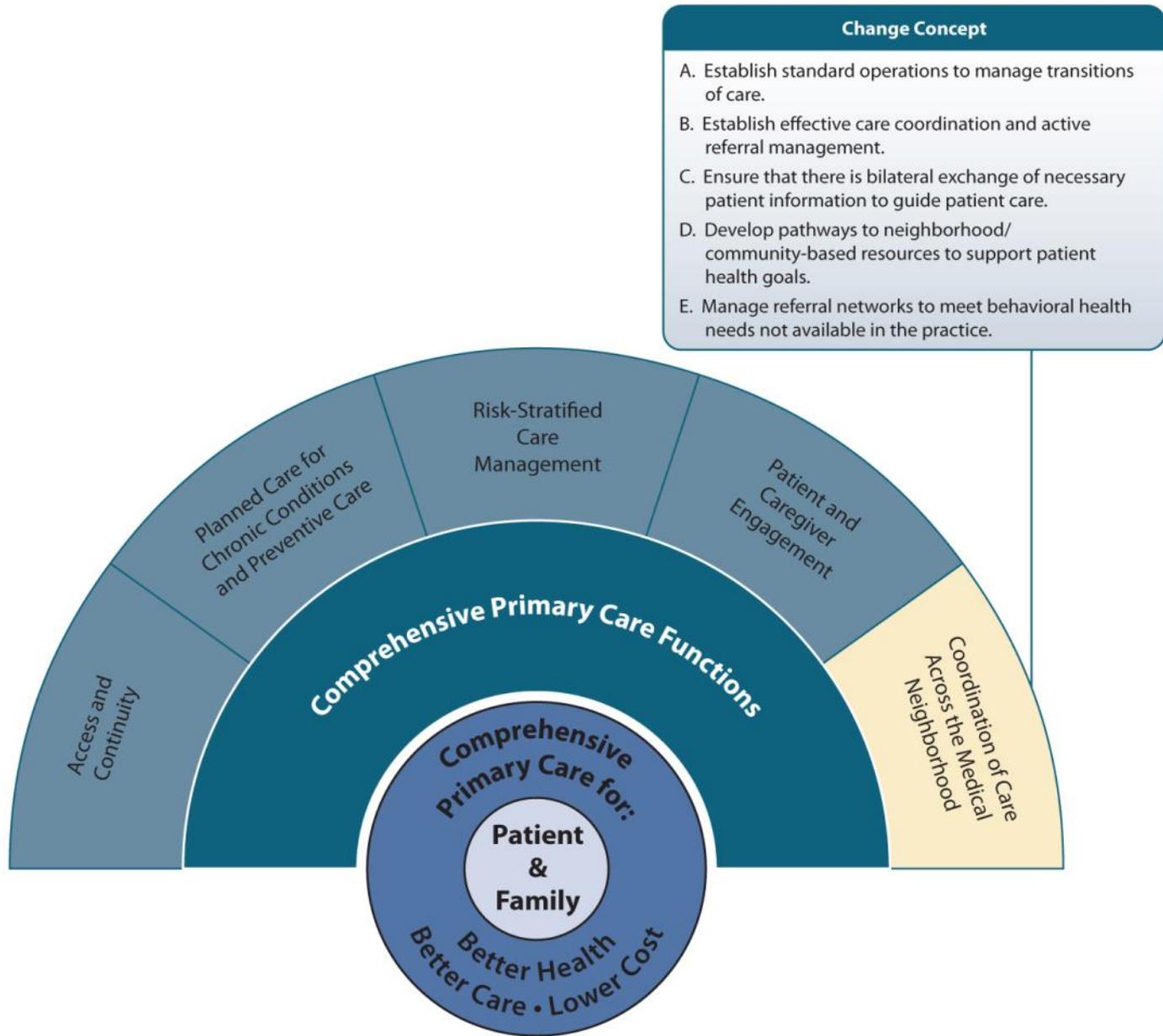
### Change Concept

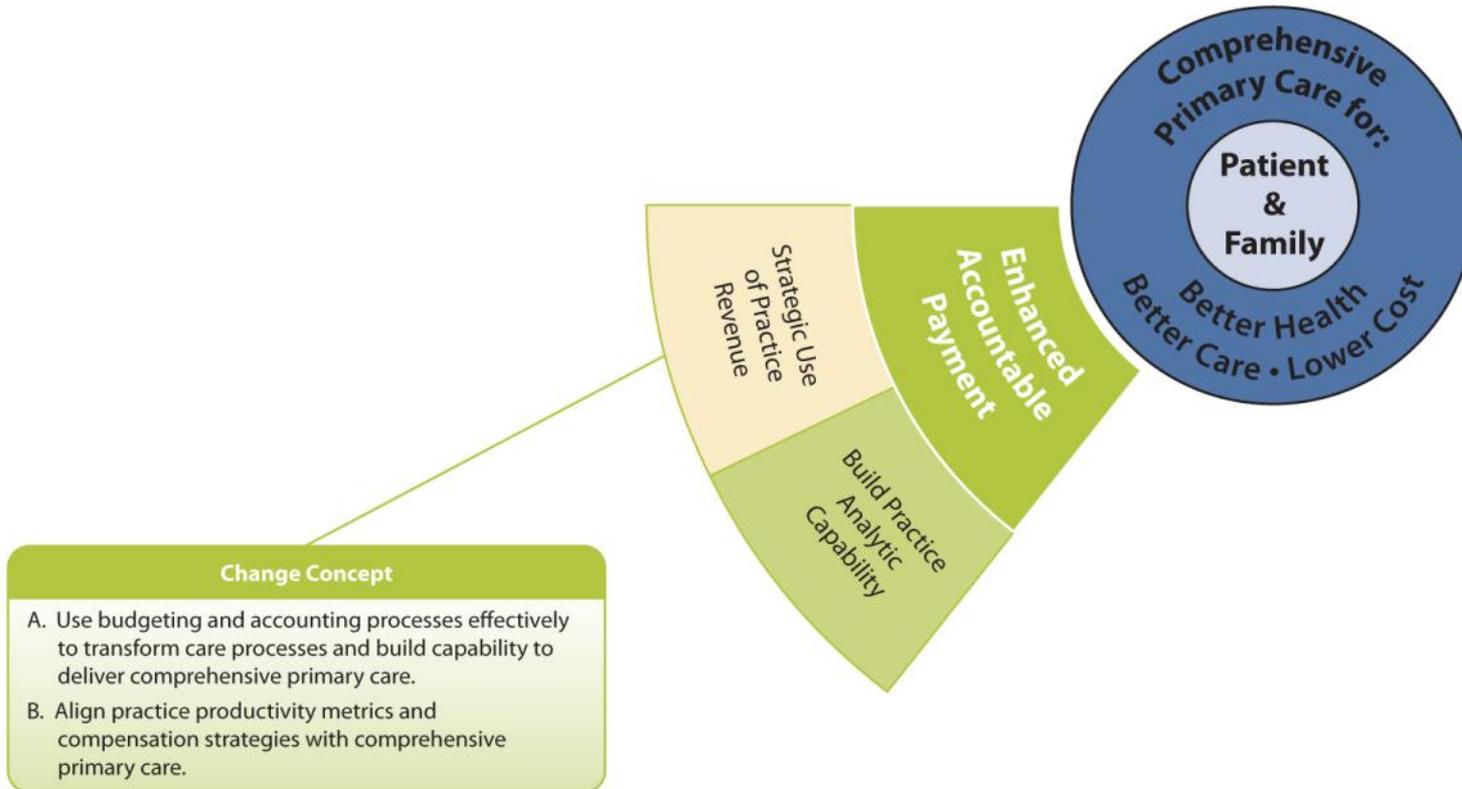
- A. Use a personalized plan of care for patients at high risk for adverse health outcome or harm.
- B. Proactively manage chronic and preventive care for empanelled patients.
- C. Manage medications to maximize efficiency, effectiveness and safety.
- D. Use team-based care to meet patient needs efficiently.
- E. Offer integrated behavioral health services to support patients with behavioral health needs, dementia and poorly controlled chronic conditions.

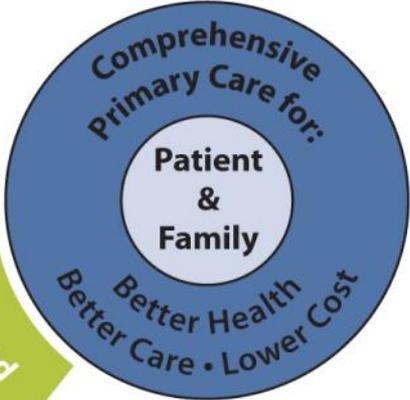






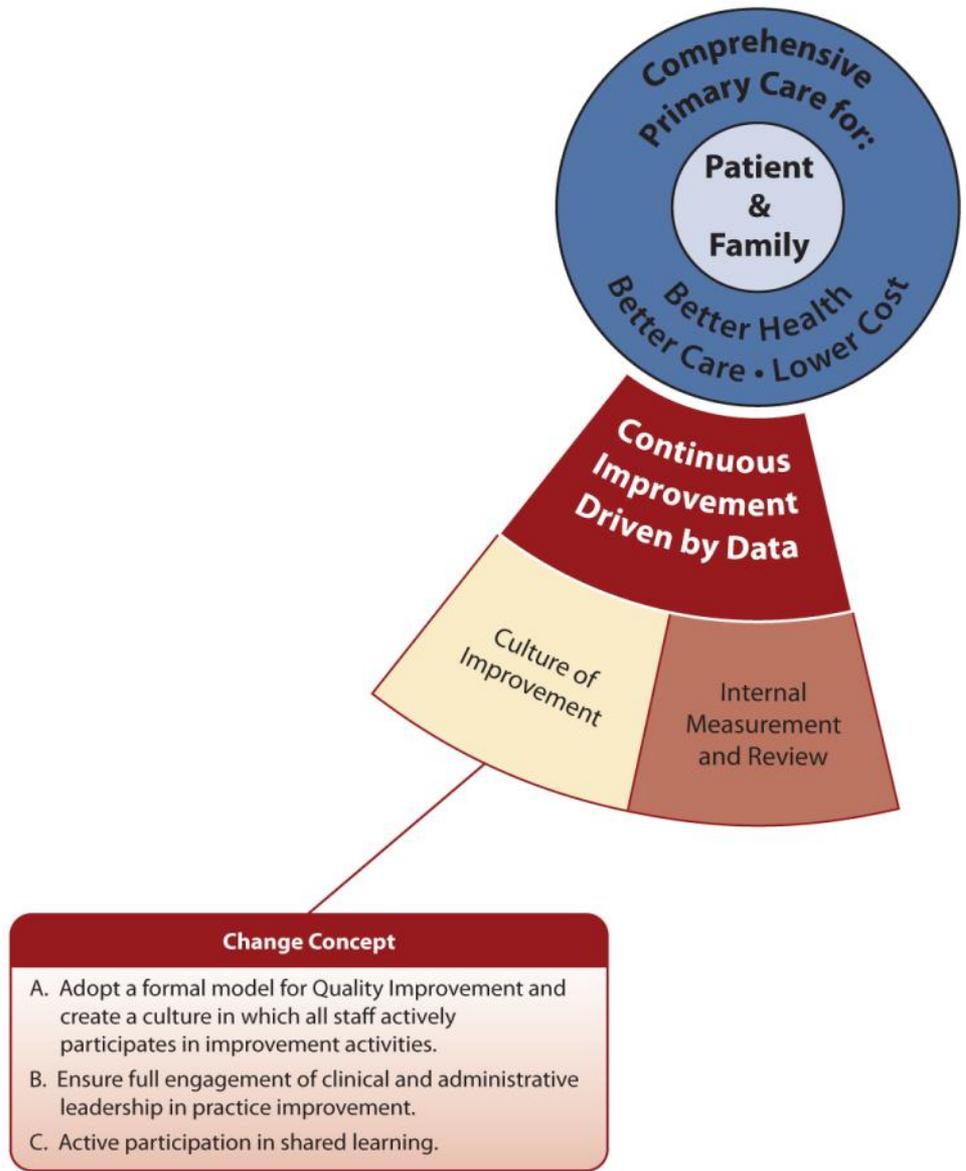


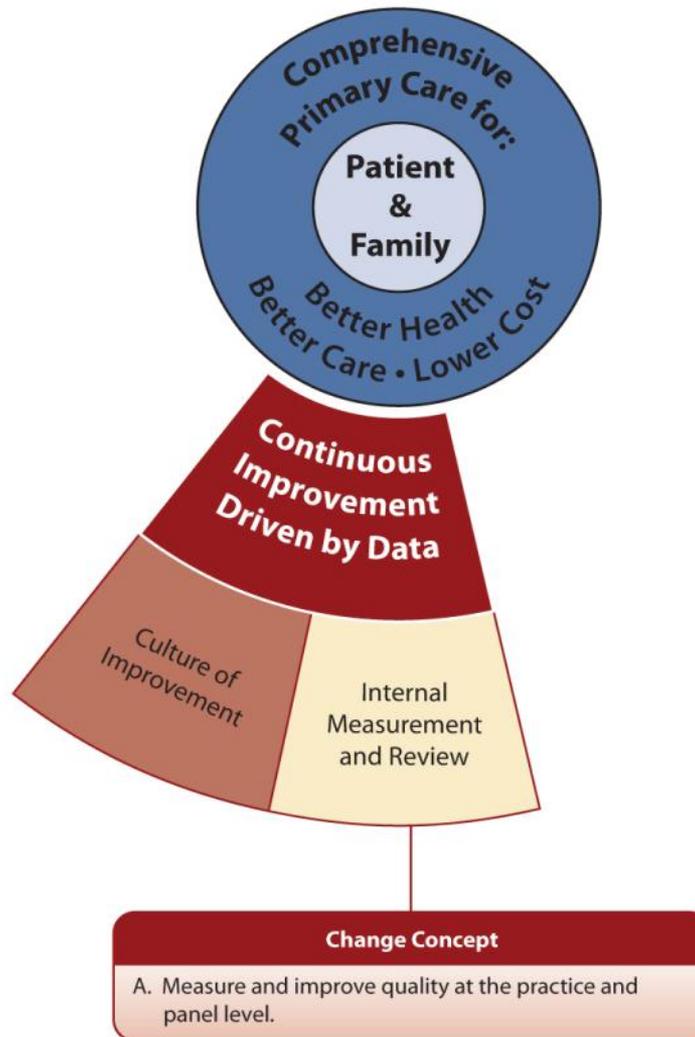


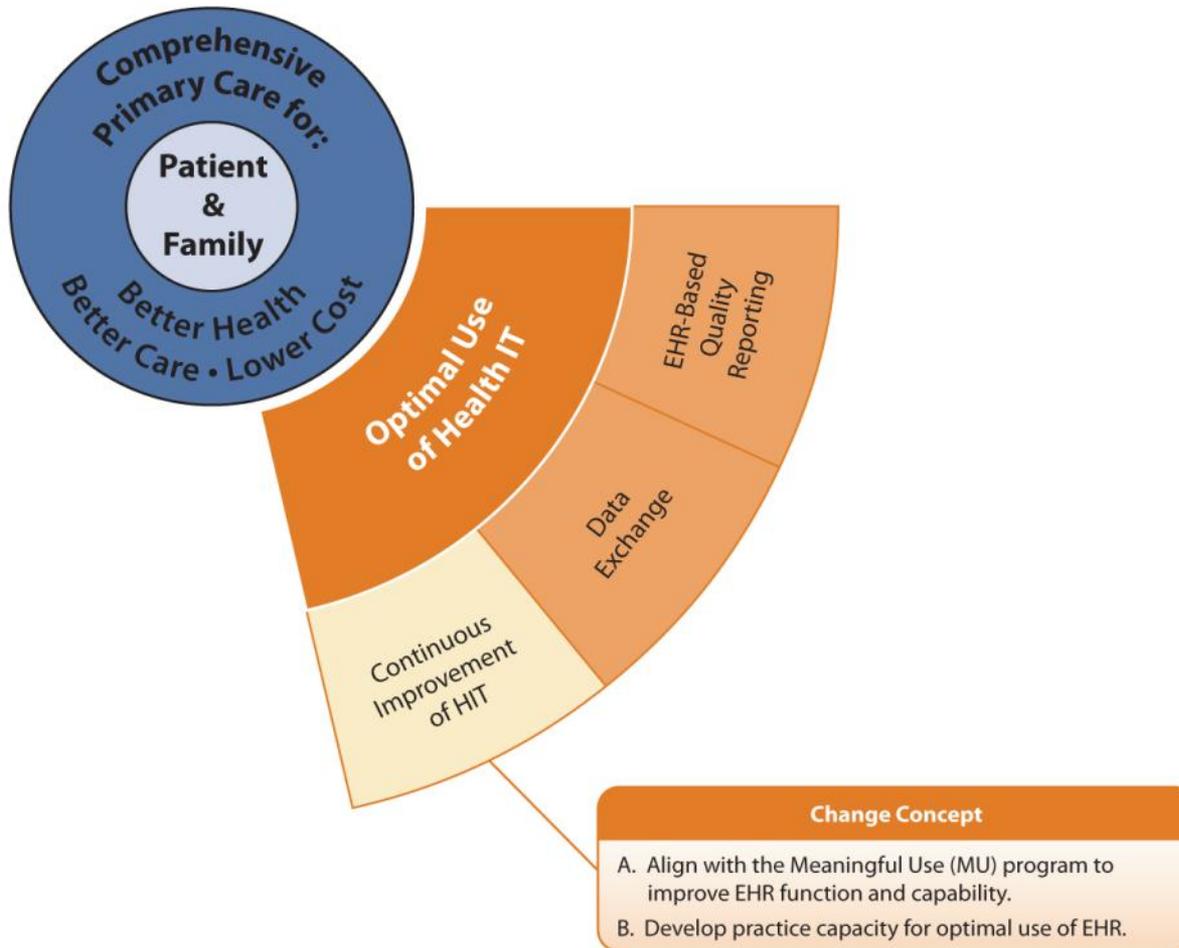


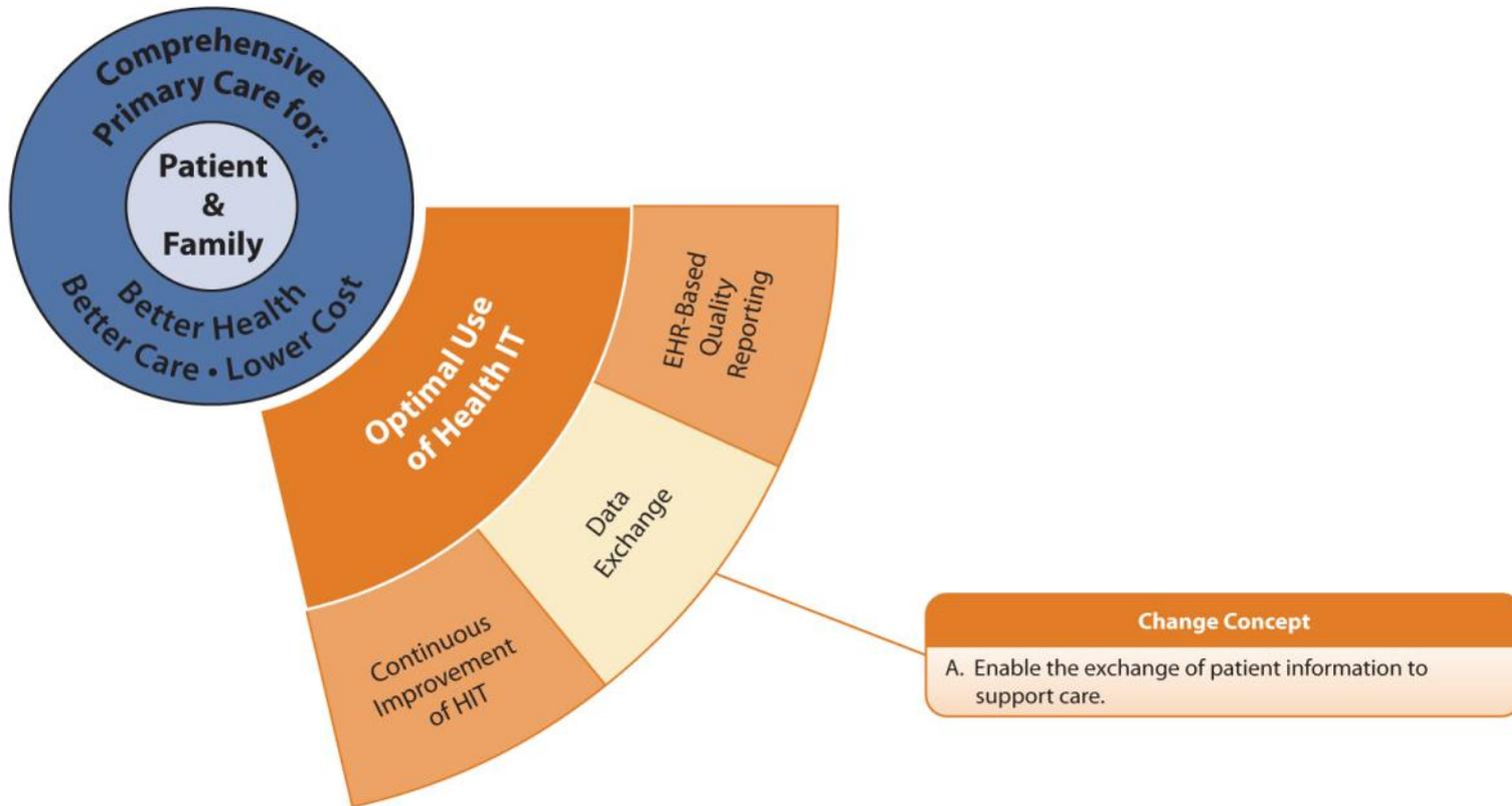
**Change Concept**

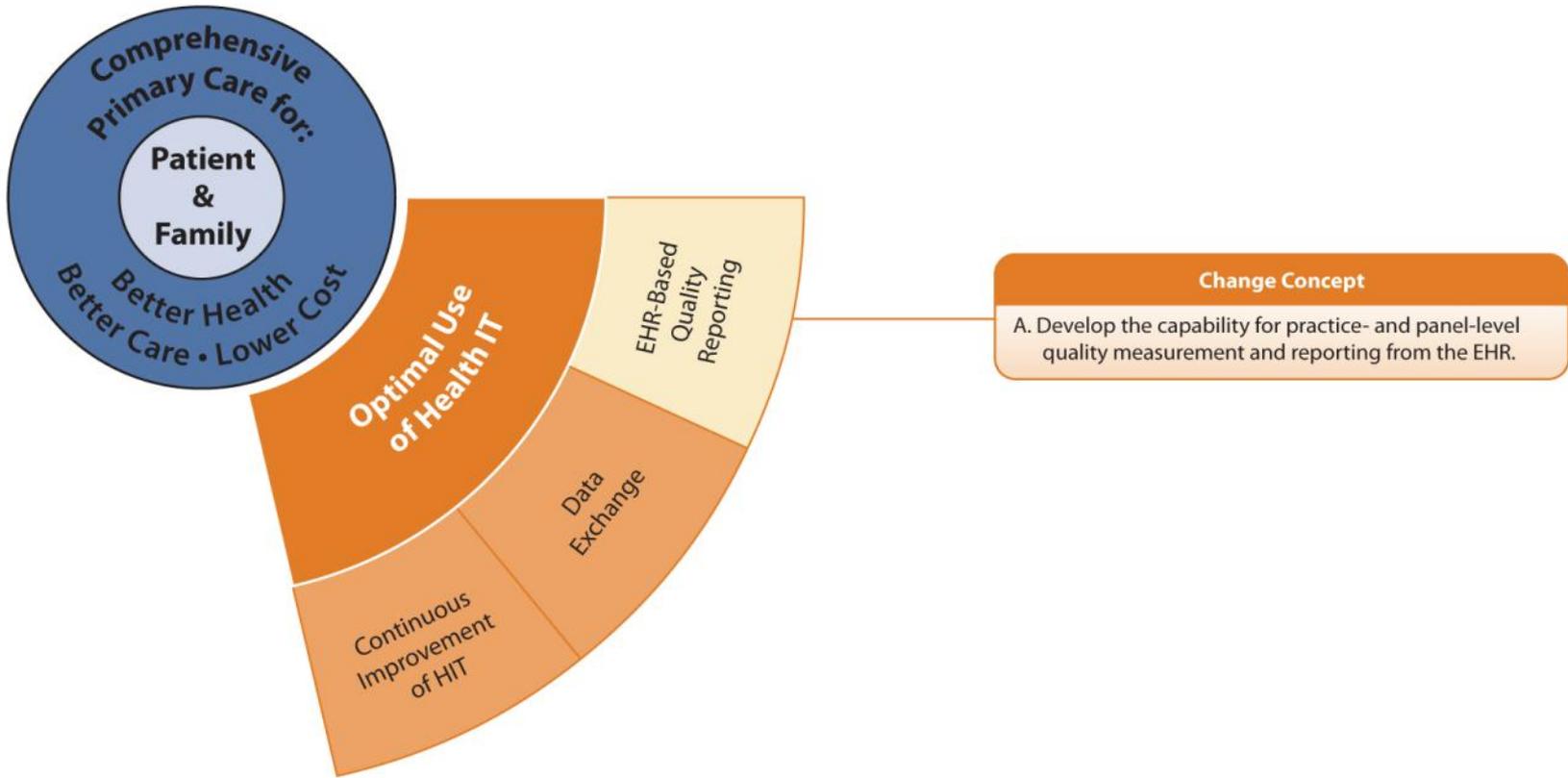
A. Build the analytic capability required to manage total cost of care for the practice population.





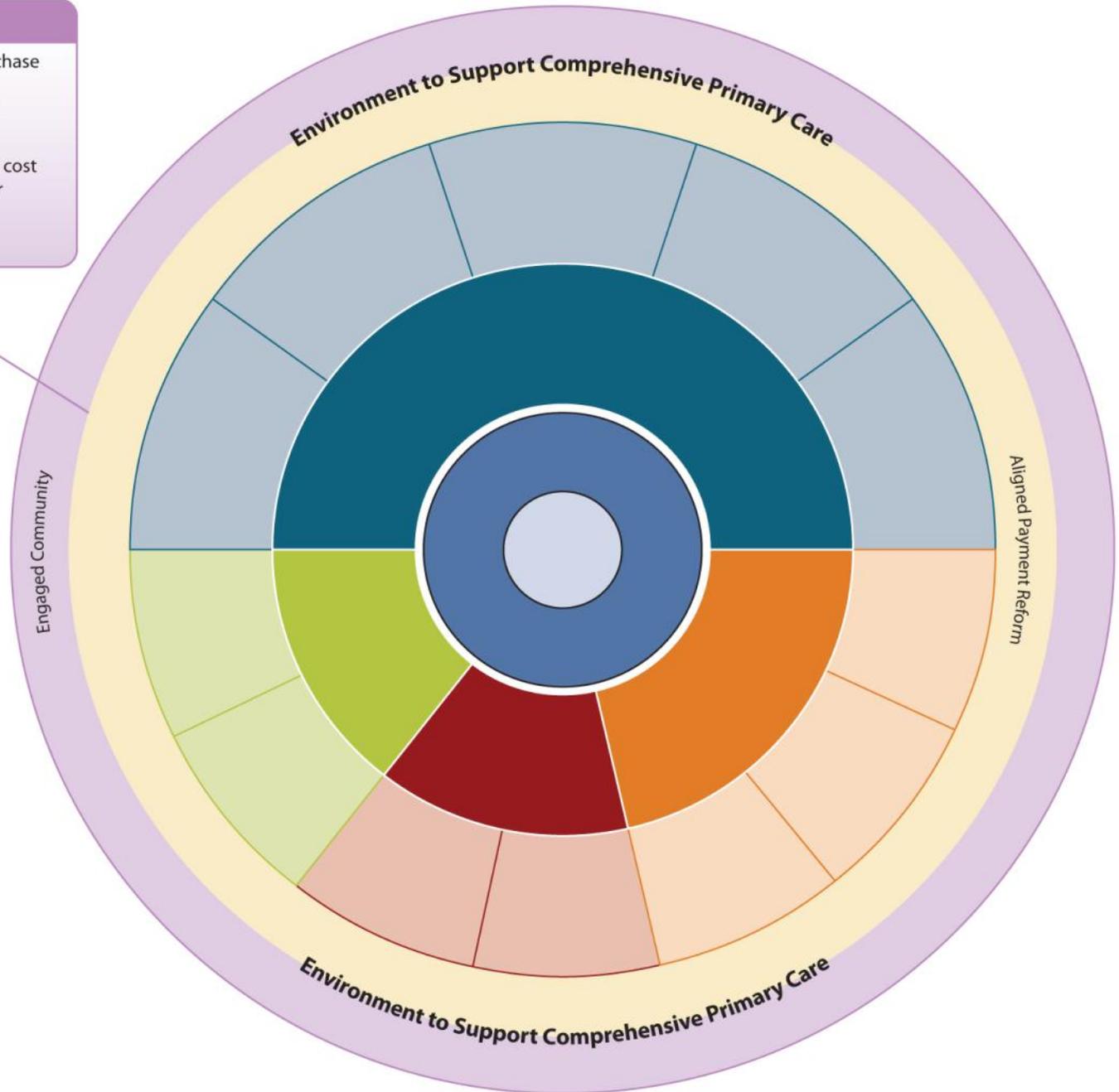






### Change Concept

- A. Use population-based payment to purchase comprehensive primary care services.
- B. Provide actionable and timely cost and utilization data to practices.
- C. Reward practice actions to reduce total cost of care through shared savings or other mechanism.
- D. Align quality measures.



### Change Concept

- A. Engage stakeholders with an interest in better care, better health outcomes and lower overall cost of care in support of CPC practices.
- B. Support processes that integrate care across the Medical Neighborhood.

