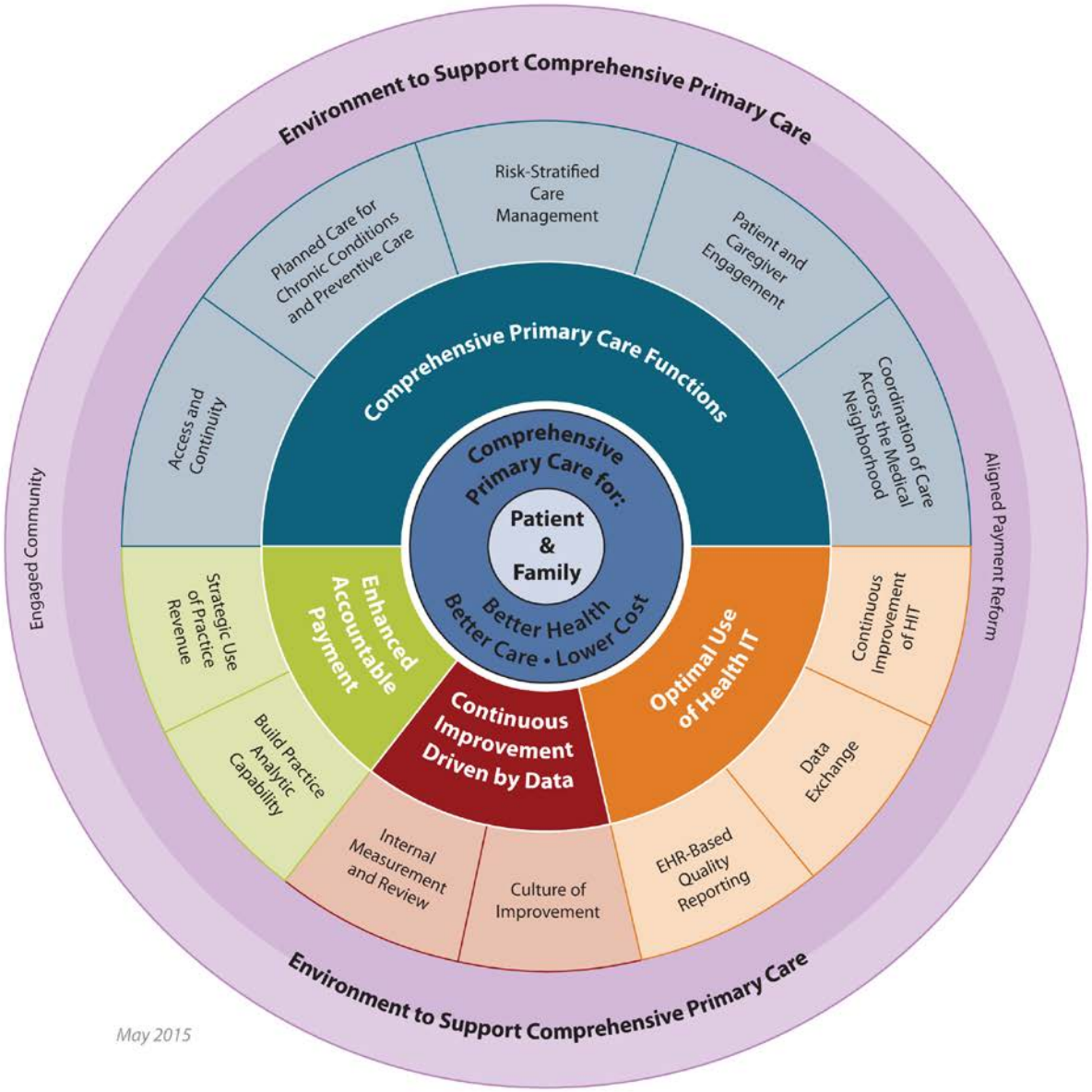
Comprehensive Primary Care Initiative Change Package and Driver Diagram, May 2015



Introduction to the Pathways Guide, May 2015

The **Pathways Guide to CPC** is a resource for practices, payers, and other health care organizations who are working through change efforts similar to those in CPC. The *CPC Key Drivers and Changes* presents a high-level view of the actions required to achieve the CPC aims of improved care, better health for populations, and lower cost. CPC practices have been working through the CPC Milestones to make these changes in their practices, build this capability, and deliver comprehensive primary care. CMS, CPC payers, and regional stakeholders have been working together to build the Environment to Support Comprehensive Primary Care (Driver 5).

You can use the *Key Drivers and Changes* as a navigational aid to understand how the CPC practices are delivering care and how CMS, our payer partners, and regional stakeholders are supporting this care delivery. The *Key Drivers and Changes* identifies the actions or drivers necessary to achieve the CPC aims and the changes (*Change Concepts*) that those actions or drivers require. The radial diagram below provides a visual representation of the drivers and changes. It is found throughout this guide and highlights the connection between drivers, changes, and change concepts. For each *Change Concept* you will find multiple search terms to explore applicable resources in this portfolio – resources that demonstrate not only "what" should be in place to do this work, but also some suggested "hows" or change tactics.

Practice change is difficult and complicated and this complexity is reflected in the multiplicity of search terms for each *Change Concept* identified in the *Key Drivers and Changes.*

The resources in this Pathways portfolio are the artifacts of real practice learning and change. They include selected web-based presentations through which practices shared their work with each other, miniature case-studies (Spotlights) through which practice changes are explored, video discussions, and a variety of tools and resources practices have used as they iteratively test and implement changes in the way they deliver care. You will see a diverse set of examples, representing the heterogeneity of practices engaged in CPC. In addition, a summary document outlines the work going on in each region to build the environment to support primary care in each CPC region.

As you use this **Pathways Guide** It will be helpful to understand the relationship between the CPC Milestones and the *Key Drivers and Changes*. The Key Drivers and Changes provide the theory of action for CPC: how properly supported primary care will produce better care, smarter spending, and healthier people. The *CPC Milestones* are the corridors of work through which the CPC practices have been developing the capabilities identified in the *Key Drivers and Changes*. CPC practices are accountable to CMS for the Milestones and report progress quarterly through a web portal. In this Guide you will be able to search by the CPC Milestones as well to understand the changes practices are making through each Milestone.

In CPC we are learning with and from the practices, payers, and regional stakeholders about the changes necessary to improve care, achieve better health outcomes, and lower the cost of care. We hope this CPC Pathway's Guide reflects that process and captures some of what has been learned.

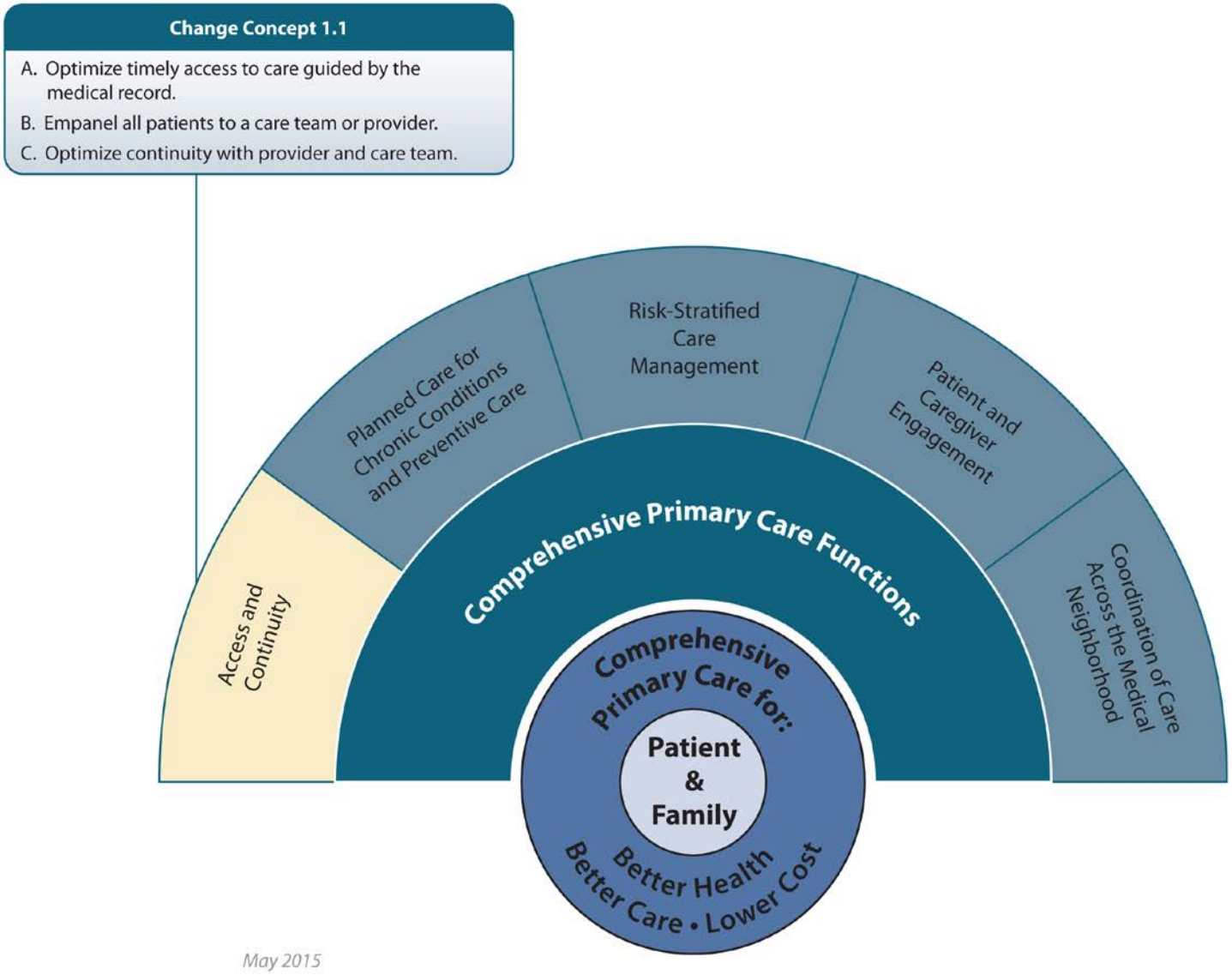
Primary Driver – 1.0 Comprehensive Primary Care Functions

Introduction to Driver 1

CPC practices have developed capabilities in the delivery of five comprehensive primary care functions to achieve better health outcomes and improve the experience of care, as well as reduce the cost of care through improvement in care. In the examples that follow you will see how CPC practices

1. **Improve access** to care fully informed by the medical record, building relationship through **continuity of car**e and maintaining continuity in management of acute and chronic conditions.
2. Use teams to provide **planned, proactive care** for chronic conditions and preventive care, integrate behavioral health services, and manage medications to maximize efficiency, effectiveness and safety.
3. Address the health of both the individual and the practice population through **risk stratification** of their practice population, management of transitions in care, and practice-based care management for those at highest risk.
4. **Engage patients, families, and caregivers** in the management of their own health and health care and in the way the practice provides that care.
5. **Coordinate care across the medical neighborhood**, serving as the hub of care for their patients, systematically bridging care handoffs and transitions, and linking to community-based resources to support their patients.

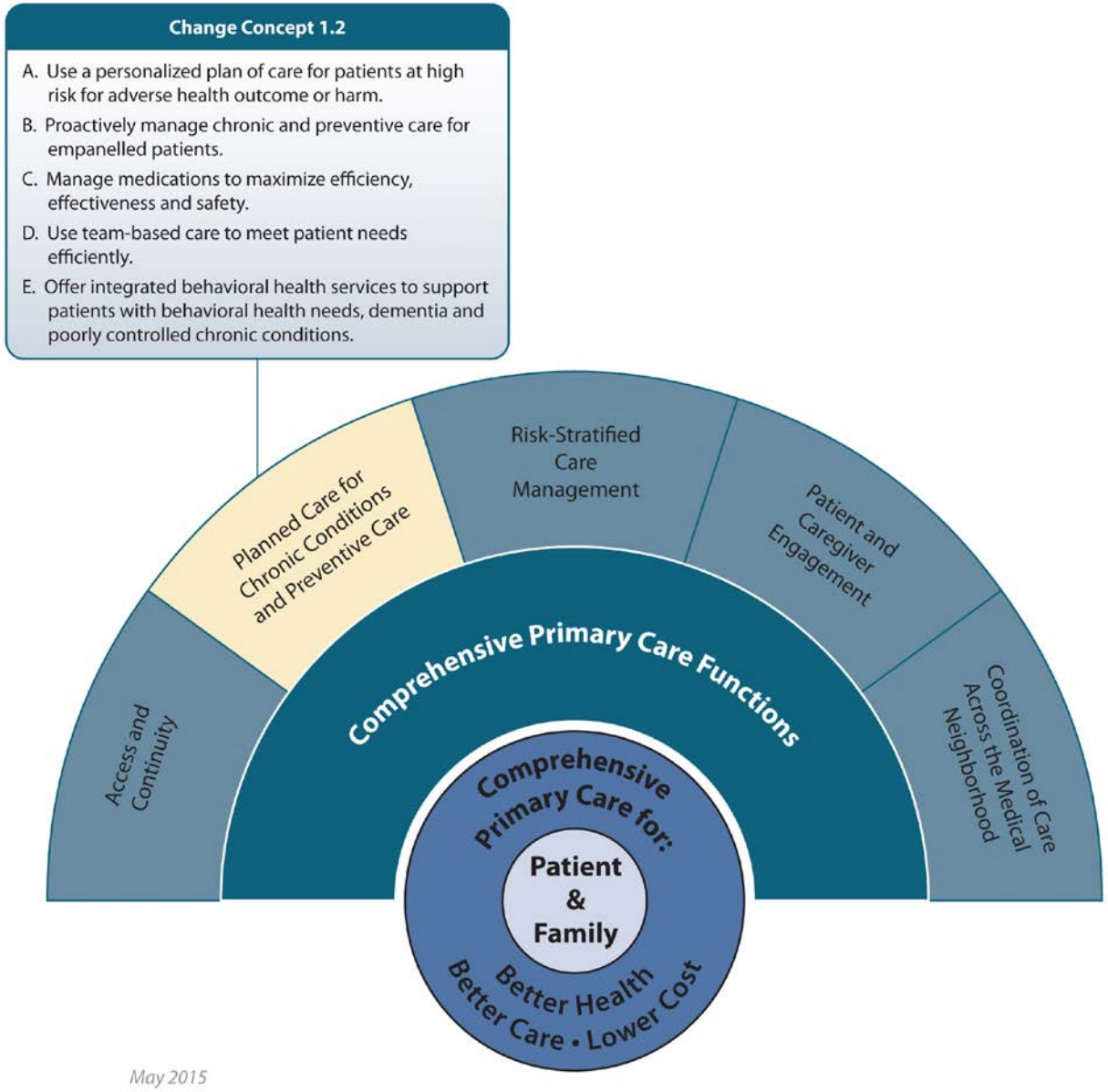
Primary Driver – 1.0 Comprehensive Primary Care Functions



Primary Driver – 1.0 Comprehensive Primary Care Functions

Secondary Driver	Change Concept	Change Tactics (Examples)	Suggested Search Terms to Locate Applicable Resources
1.1 **Access and Continuity**	A: Optimize timely access to care guided by the medical record.	• Provide 24/7 access to provider or care team for advice about urgent and emergent care, for example: • Provider/care team with access to medical record • Cross-coverage with access to medical record • Protocol-driven nurse line with access to medical record • Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate small practices to provide alternate hours office visits and urgent care). • Use alternatives to increase access to care-team and provider, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers). • Provide same-day or next-day access to a consistent provider or care team when needed for urgent care or transition management. • Provide a patient portal for patient-controlled access to health information.	• Milestone 3, Milestone 3 action group, 24/7, access, asynchronous access, continuity, e-visit, empanel, enhanced access, group visit, portal, virtual office • Milestone 6, care compacts, care contracts, HIE, information exchange, medical neighborhood
	B: Empanel all patients to a care team or provider.	• Empanel (assign responsibility for) the total population, linking each patient to a provider or care team.	• Milestone 2, Milestone 2 action group, continuity, empanel
	C: Optimize continuity with provider and care team.	• Measure continuity between patient and provider and/or care team. • Use scheduling strategies that optimize continuity while accounting for needs for urgent access. • Use a shared care plan to ensure continuity of management between within the practice and with consultants (for high risk only). • Ensure that all providers within the practice and all members of the care team have access to the same patient information to guide care.	• Milestone 2, Milestone 2 action group, care management, care plan, care team, continuity, high risk, highest need • Milestone 3, Milestone 3 action group, 24/7, continuity, enhanced access, process measures • Milestone 6, Milestone 6 action group, care coordination, medical neighborhood

Primary Driver – 1.0 Comprehensive Primary Care Functions



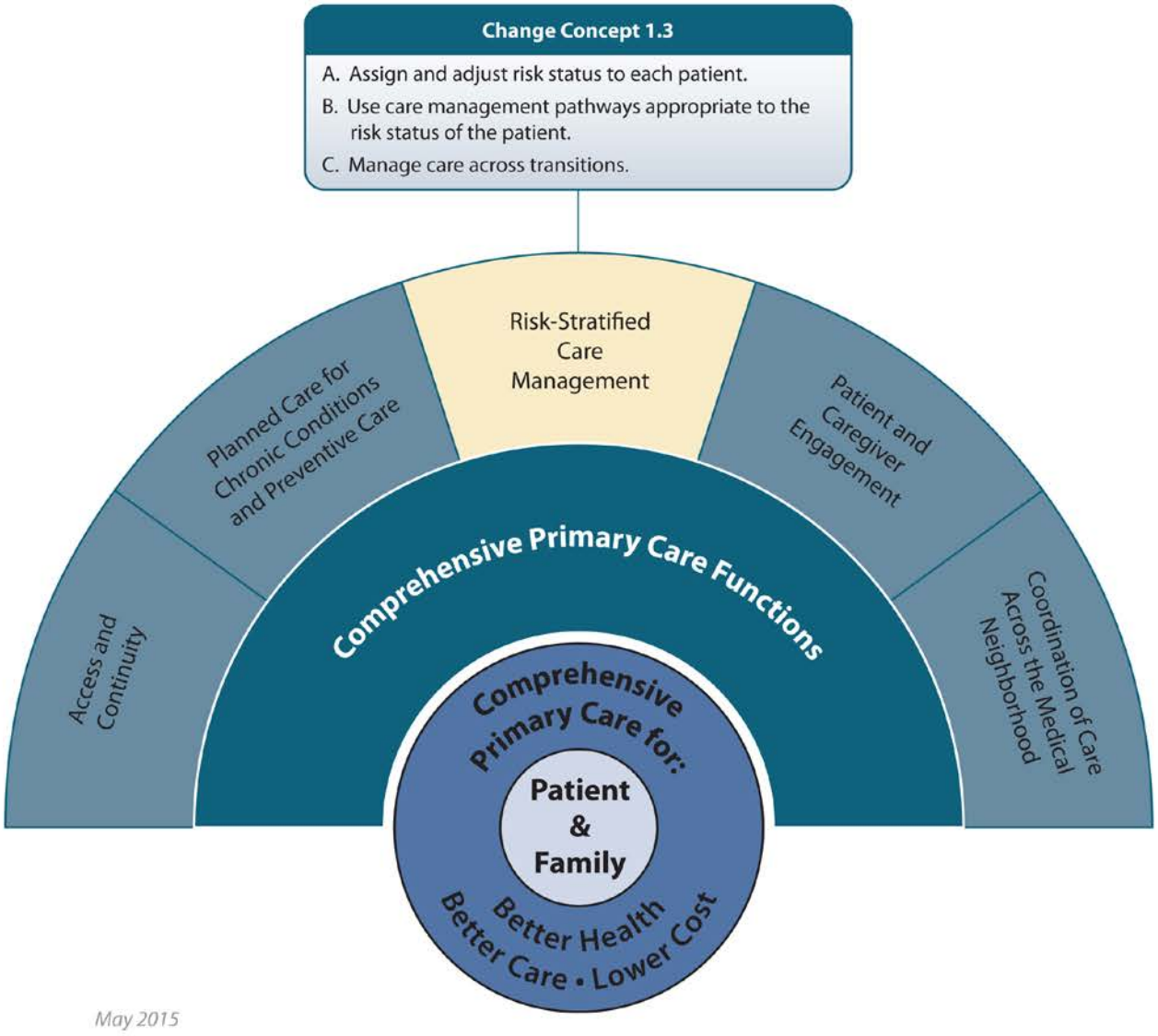
Primary Driver – 1.0 Comprehensive Primary Care Functions

Secondary Driver	Change Concept	Change Tactics (Examples)	Suggested Search Terms to Locate Applicable Resources
1.2 **Planned Care for Chronic Conditions and Preventive Care**	A: Use a personalized plan of care for patients at high risk for adverse health outcome or harm.	• Engage patients at highest risk in ongoing development and refinement of their care management plan, to include integration of patient goals, values and priorities. • Use the Medicare Annual Wellness Visit with Personalized Prevention Plan Services (AWV with PPPS) for Medicare patients.	• Milestone 2, Milestone 2 action group, care management, care plan, continuity, high risk, highest need, patient engagement, patient experience, motivational interview, reflective listening
	B: Proactively manage chronic and preventive care for empanelled patients.	• Provide patients annually with an opportunity for development and/or adjustment of an individualized plan of care, including health risk appraisal; gender, age and condition-specific preventive care services; plan of care for chronic conditions; and advance care planning. • Use condition-specific pathways for care of chronic conditions (e.g., hypertension, diabetes, depression, asthma and heart failure) with evidence-based protocols to guide treatment to target. • Use pre-visit planning to optimize team management of patients with chronic conditions. • Use panel support tools (registry functionality) to identify services due. • Use reminders and outreach (e.g., phone calls, emails, postcards, patient portals and community health workers where available) to alert and educate patients about services due.	• Milestone 2, Milestone 2 action group, care coordination, care management, care plan, end of life, evidence based decision, high risk, panel management, patient engagement, patient experience, motivational interview, pre-visit planning, reflective listening • Milestone 3, Milestone 3 action group, communication, portal • Milestone 5, continuous quality improvement • Milestone 7, Milestone 7 action group, shared decision making
	C: Manage medications to maximize efficiency, effectiveness and safety.	• Periodic medication reconciliation. • Coordinate medications across transitions of care settings and providers. • Integrate a clinical pharmacist as part of the care team. • Conduct periodic, structured medication reviews. • Develop a medication action plan for high-risk patients. • Provide collaborative drug therapy management for selected conditions or medications. • Provide support for medication self-management.	• Milestone 2, Milestone 2 action group, advanced primary care strategies, care plan, collaborative drug therapy, high risk, medication management, medication reconciliation, pharmacy, self-management support

Primary Driver – 1.0 Comprehensive Primary Care Functions

Secondary Driver	Change Concept	Change Tactics (Examples)	Suggested Search Terms to Locate Applicable Resources
	D: Use team-based care to meet patient needs efficiently.	• Define roles and distribute tasks among care team members, consistent with the skills, abilities and credentials of team members to better meet patient needs. • Use decision support and protocols to manage workflow in the team to meet patient needs. • Manage workflow to address chronic and preventive care, for example through pre-visit planning or huddles. • Enhance team resources with staff such as health coach, nutritionist, behavioral health, pharmacy and physical therapy as feasible to meet patient needs.	• Milestone 2, Milestone 2 action group, behavioral health, care coordination, care team, coach, culture, pharmacy, pre-visit planning, workflow • Milestone 5, continuous quality improvement
	E: Offer integrated behavioral health services to support patients with behavioral health needs, dementia and poorly controlled chronic conditions.	• Ensure PCPs and other clinical staff has been trained in principles of behavioral health care and are able to handle routine behavioral health care needs. • Include use of non-clinical staff to provide screening and assessment of behavioral health care needs. • Ensure regular communication and coordinated workflows between primary care and behavioral health providers. • Conduct regular case reviews for at-risk or unstable patients and those who are not responding to treatment. • Use the registry function of the EHR or a shared registry to support active care management and outreach to patients in treatment. • Integrate behavioral health and medical care plans and facilitate integration through co-location of services when feasible.	• Milestone 2, Milestone 2 action group, advance primary care strategy, behavioral health, care management, case management, high risk, MDQ, PHQ, workflow • Milestone 6, Milestone 6 action group, care compacts, care contracts, communication, medical neighborhood, referrals

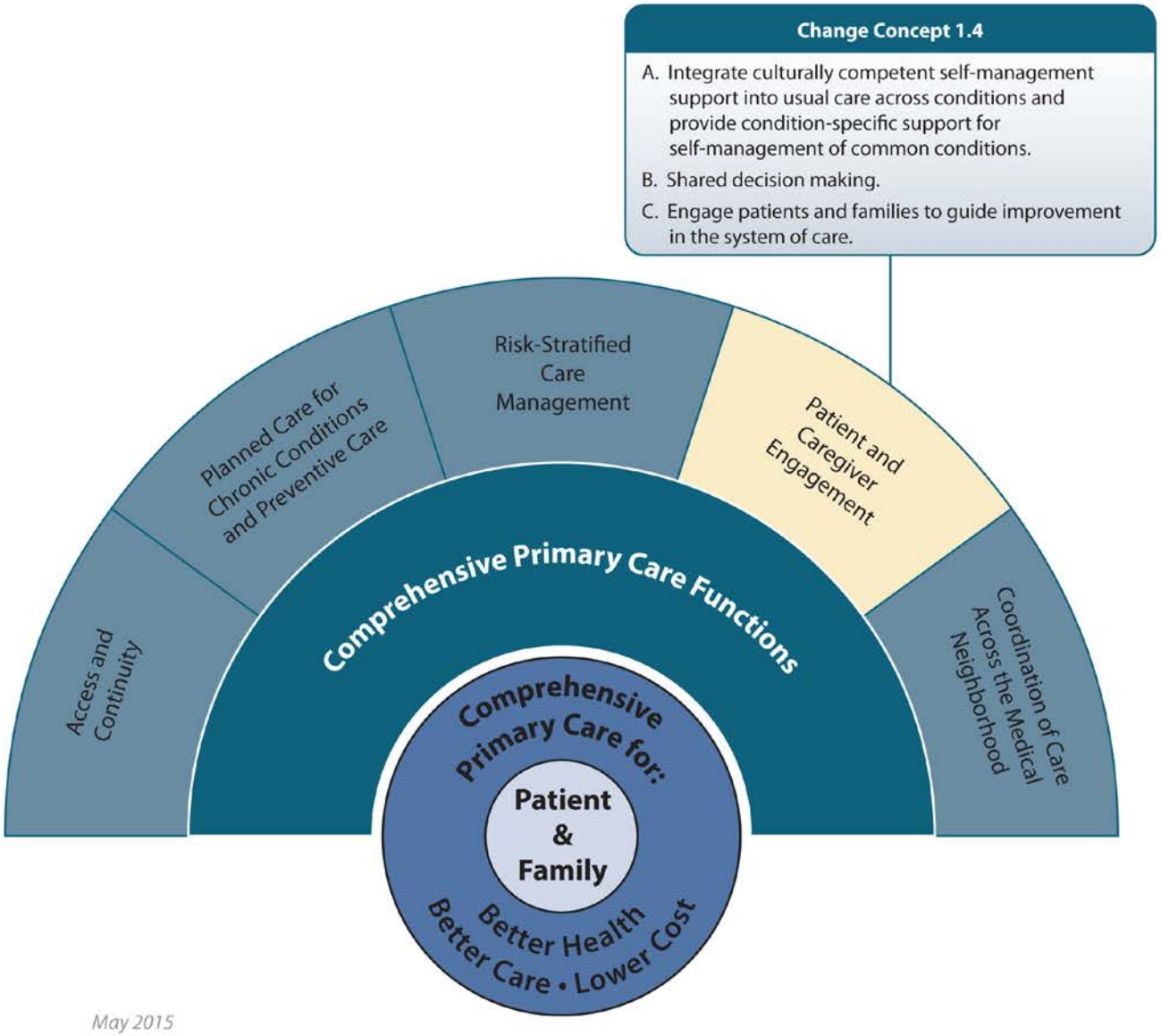
Primary Driver – 1.0 Comprehensive Primary Care Functions



Primary Driver – 1.0 Comprehensive Primary Care Functions

Secondary Driver	Change Concept	Change Tactics (Examples)	Suggested Search Terms to Locate Applicable Resources
1.3 **Risk-Stratified Care Management**	A: Assign and adjust risk status to each patient.	• Use a consistent method to assign and adjust global risk status for all empanelled patients to allow risk stratification into actionable risk cohorts.	• Milestone 2, Milestone 2 action group, care management, empanel, panel management, risk stratification
	B: Use care management pathways appropriate to the risk status of the patient.	• Use on-site practice-based or shared care managers to proactively monitor and coordinate care for the highest risk cohort of patients. • Use panel management and registry capabilities to support management of patients at low and intermediate risk.	• Milestone 2, Milestone 2 action group, care management, care manager, care coordination, care coordinator, care plan, high risk, panel management, risk stratification
	C: Manage care across transitions.	• Routine and timely follow-up to hospitalizations. • Routine and timely follow-up to ED visits.	• Milestone 6, Milestone 6 action group, follow up, HIE, information exchange, transitions in care

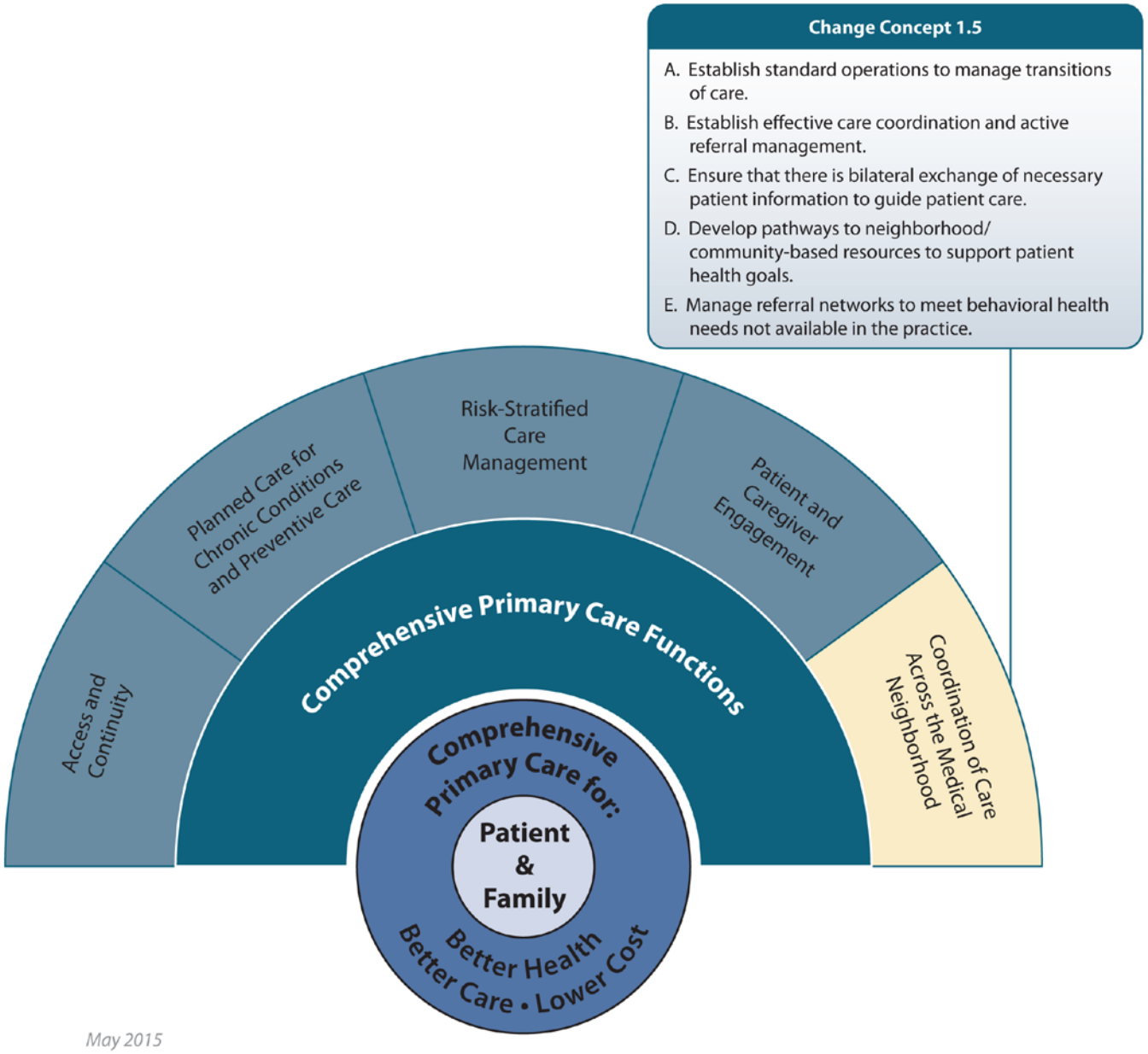
Primary Driver – 1.0 Comprehensive Primary Care Functions



Primary Driver – 1.0 Comprehensive Primary Care Functions

Secondary Driver	Change Concept	Change Tactics (Examples)	Suggested Search Terms to Locate Applicable Resources
1.4 **Patient and Caregiver Engagement**	A: Integrate culturally competent self-management support into usual care across conditions and provide condition-specific support for self-management of common conditions.	• Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the EHR. • Incorporate evidence-based techniques to promote self-management into usual care, using techniques such as goal setting with structured follow-up, Teach Back, action planning or Motivational Interviewing. • Use tools to assist patients in assessing their need for support for self-management (e.g., the Patient Activation Measure or How's My Health). • Provide a pre-visit development of a shared visit agenda with the patient. • Provide coaching between visits with follow-up on care plan and goals. • Provide peer-led support for self-management. • Provide group visits for common chronic conditions (e.g., diabetes). • Provide condition-specific chronic disease self-management support programs or coaching or link patients to those programs in the community. • Provide self-management materials at an appropriate literacy level and in an appropriate language.	• Milestone 2, Milestone 2 action group, care plan, coach, family engagement, group visit, motivational interview, PAM, patient engagement, pre-visit plan, referrals, reflective listening, self-management support, teach back • Milestone 6, Milestone action group, medical neighborhood, referrals
	B: Shared decision making.	• Use evidence-based decision aids to provide information about risks and benefits of care options in preference-sensitive conditions. • Routinely share test results, along with appropriate education about the implications of those results, with patients.	• Milestone 7, Milestone 7 action group, communication, decision aid, preference sensitive conditions, patient engagement, patient summary, reflective listening, shared decision making
	C: Engage patients and families to guide improvement in the system of care.	• Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms. • Communicate to patients the changes being implemented by the practice.	• Milestone 4, Milestone 4 action group, CAHPS, communication, patient experience, patient family advisory council, surveys

Primary Driver – 1.0 Comprehensive Primary Care Functions



Primary Driver – 1.0 Comprehensive Primary Care Functions

Secondary Driver	Change Concept	Change Tactics (Examples)	Suggested Search Terms to Locate Applicable Resources
1.5 **Coordination of Care Across the Medical Neighborhood**	A: Establish standard operations to manage transitions of care.	• Formalize lines of communication with local care settings in which empanelled patients receive care to ensure documented flow of information and clear transitions in care. • Partner with community or hospital-based transitional care services.	• Milestone 2, Milestone 2 action group, care coordination, care management • Milestone 6, Milestone 6 action group, communication, HIE, information exchange, medical neighborhood, transitions in care
	B: Establish effective care coordination and active referral management	• Establish care coordination agreements with frequently used consultants that set expectations for documented flow of information and provider expectations between settings. • Track patients referred to specialist through the entire process. • Systematically integrate information from referrals into the plan of care.	• Milestone 2, Milestone 2 action group, care coordination, care plan, integration, workflow • Milestone 6, Milestone 6 action group, care compacts, care contracts, follow up, HIE, medical neighborhood, referrals, transitions in care
	C: Ensure that there is bilateral exchange of necessary patient information to guide patient care.	• Participate in Health Information Exchange if available. • Use structured referral notes.	• Milestone 6, Milestone 6 action group, care compacts, care contracts, care coordination, HIE, medical neighborhood, referrals, transitions in care
	D: Develop pathways to neighborhood/ community-based resources to support patient health goals.	• Maintain formal (referral) links to community-based chronic disease self-management support programs, exercise programs and other wellness resources with the potential for bidirectional flow of information. • Provide a guide to available community resources.	• Milestone 2, Milestone 2 action group, self-management support • Milestone 6, Milestone 6 action group, care compacts, care contracts, care coordination, communication, medical neighborhood, referrals
	E: Manage referral networks to meet behavioral health needs not available in the practice.	• Develop formal referral relationships with mental health and substance abuse services in the community.	• Milestone 2, Milestone 2 action group, behavioral health integration • Milestone 6, Milestone 6 action group, care compacts, care contracts, medical neighborhood, referrals

Primary Driver – 2.0 Enhanced Accountable Payment

Introduction

CPC practices use the population-based payments they receive from multiple commercial and public payers to deliver comprehensive primary care. They are strategic in their use of these alternate payment resources to build and sustain the capability to deliver the comprehensive primary care functions and are investing in the analytic capability they will need to meet the health care needs of their population with attention to the cost of care.

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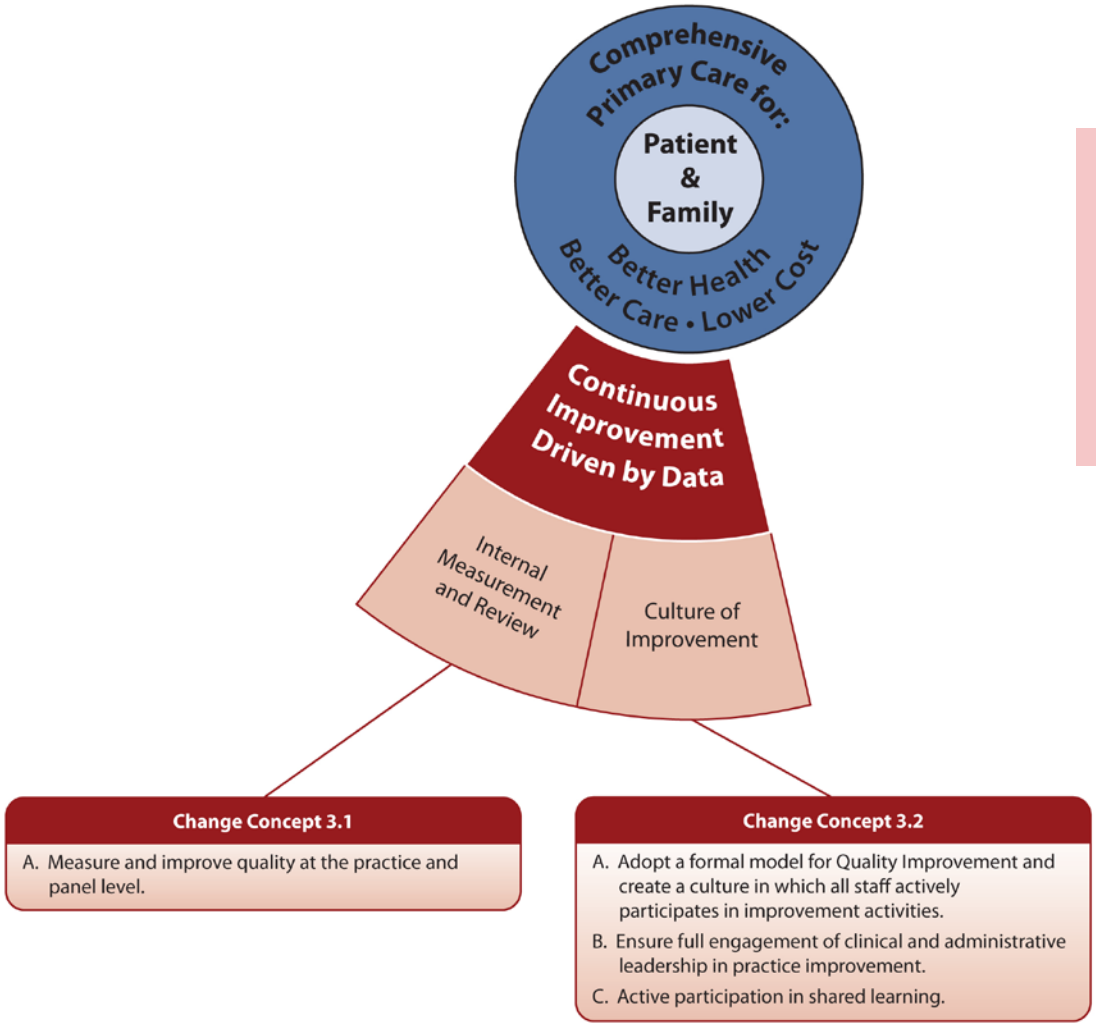
Primary Driver – 2.0 Enhanced Accountable Payment

Secondary Driver	Change Concept	Change Tactics (Examples)	Suggested Search Terms to Locate Applicable Resources
2.1 **Strategic Use of Practice Revenue**	A: Use budgeting and accounting processes effectively to transform care processes and build capability to deliver comprehensive primary care.	• Develop a process for prioritizing practice changes necessary to improve patient outcomes and population health. • Invest revenue in priority areas for practice transformation. • Use accounting and budgeting tools and processes to allocate revenue.	• Milestone 1, budget, expense, financials, fiscal, investment, revenue
	B: Align practice productivity metrics and compensation strategies with comprehensive primary care.	• Use productivity measures that include non-visit related care. • Incent effective team-based care.	• Milestone 1, budget, expense, financials, fiscal, measure, payroll, revenue, shared savings
2.2 **Analytic Capability**	A: Build the analytic capability required to manage total cost of care for the practice population.	• Train appropriate staff on interpretation of cost and utilization information. • Use available data regularly to analyze opportunities to reduce cost through improved care.	• Milestone 1, budget, expense, financials, fiscal, investment, utilization • Milestone 5, analytic capability, clinical quality measure, feedback reports, outcome measures, utilization

Primary Driver – 3.0 Continuous Improvement Driven by Data



Introduction

CPC practices are rapidly changing how they provide care, using data provided by the payers and measurement in the practice and at the level of the care team to guide these changes. This effort requires active and engaged leadership, staff with commitment and improvement skills, and the allocation of time and resources to the process of practice change and improvement.

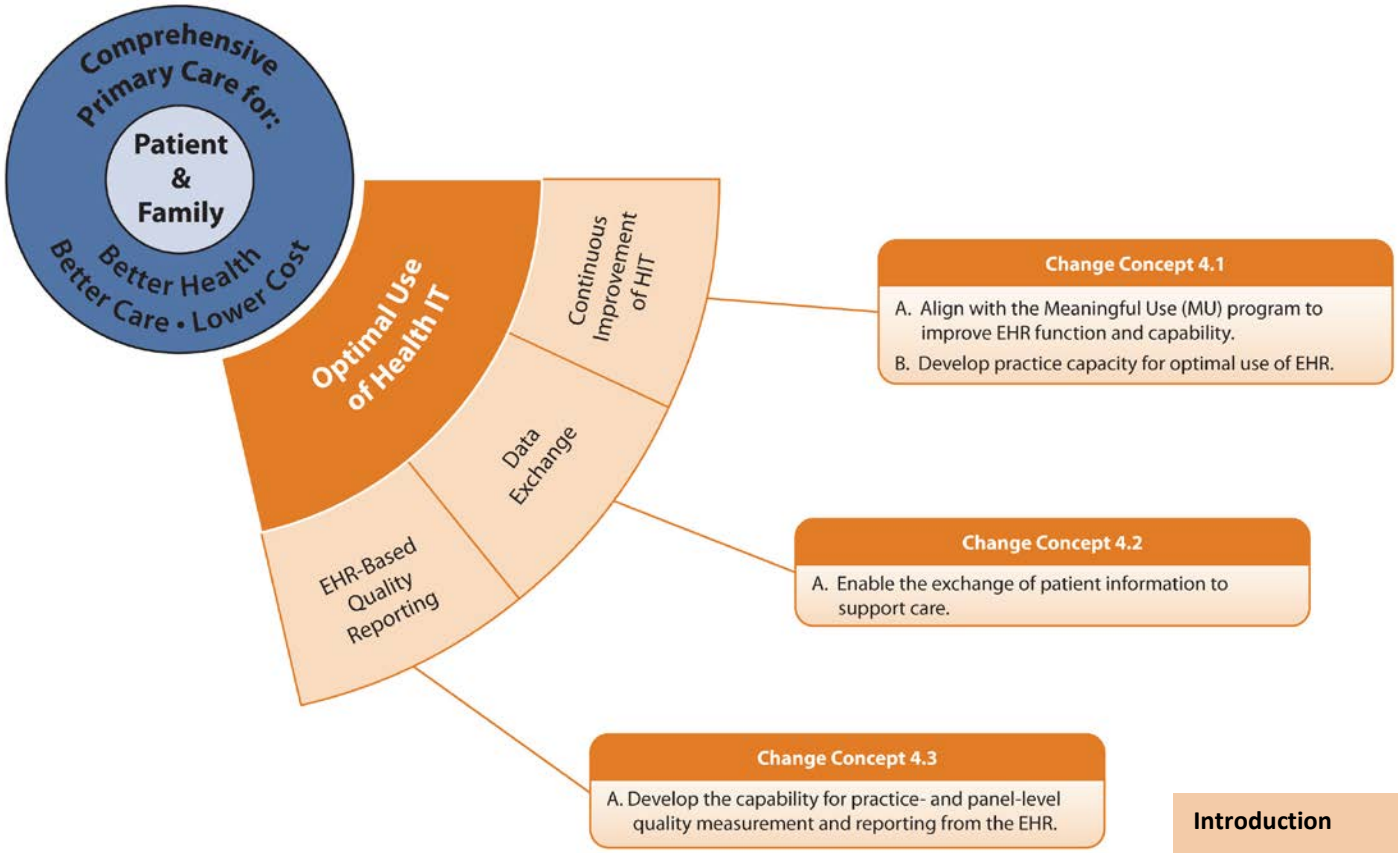
Primary Driver – 3.0 Continuous Improvement Driven by Data

Secondary Driver	Change Concept	Change Tactics (Examples)	Suggested Search Terms to Locate Applicable Resources
3.1 Internal Measurement and Review	A: Measure and improve quality at the practice and panel level.	• Identify a set of EHR-derived clinical quality and utilization measures that are meaningful to the practice team. • Regularly review measures of quality, utilization, patient satisfaction and other measures that may be useful at the practice level and at the level of the care team or provider (panel). • Use relevant data sources to create benchmarks and goals for performance at the practice level and panel level.	• Milestone 5, analytic capability, CAHPS, clinical quality measure, continuous quality improvement, feedback reports, measure, utilization
3.2 Culture of Improvement	A: Adopt a formal model for Quality Improvement and create a culture in which all staff actively participates in improvement activities.	• Train all staff in quality improvement methods. • Integrate practice change/quality improvement into staff duties. • Engage all staff in identifying and testing practices changes. • Designate regular team meetings to review data and plan improvement cycles. • Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff. • Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families.	• All Milestones, communication, culture of improvement, integration, outcome measures, patient engagement, process measures, workflow • Milestone 5, analytic capability, clinical quality measure, continuous quality improvement, feedback reports, utilization, CAHPS
	B: Ensure full engagement of clinical and administrative leadership in practice improvement.	• Make responsibility for guidance of practice change a component of clinical and administrative leadership roles. • Allocate time for clinical and administrative leadership for practice improvement efforts, including participation in regular team meetings. • Incorporate population health, quality and patient experience metrics in regular reviews of practice performance.	• All Milestones, culture of improvement • Milestone 1, budget • Milestone 4, Milestone 4 action group, CAHPS, patient experience, surveys • Milestone 5, clinical quality measures, continuous quality improvement outcome measures, population health, process measures

Primary Driver – 3.0 Continuous Improvement Driven by Data

Secondary Driver	Change Concept	Change Tactics (Examples)	Suggested Search Terms to Locate Applicable Resources
	C: Active participation in shared learning.	• Share lessons learned from practice changes (successful and unsuccessful changes) and useful tools and resource materials with other practices. • Engage with other practices through transparent sharing of common measures used to guide practice change. • Access available expertise to assist in practice changes of strategic importance to the practice.	• Milestone 8, communication, culture of improvement

Primary Driver – 4.0 Optimal Use of Health IT



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Introduction

CPC practices are adapting workflows to fully use the capabilities of the electronic health record (EHR) to manage patients and population. Through EHR-based quality reporting they link quality measurement and improvement to daily clinical care and documentation. Participation in regional health information exchanges, when available, helps them to more effectively bridge the seams of care in their medical neighborhood.

Primary Driver – 4.0 Optimal Use of Health IT

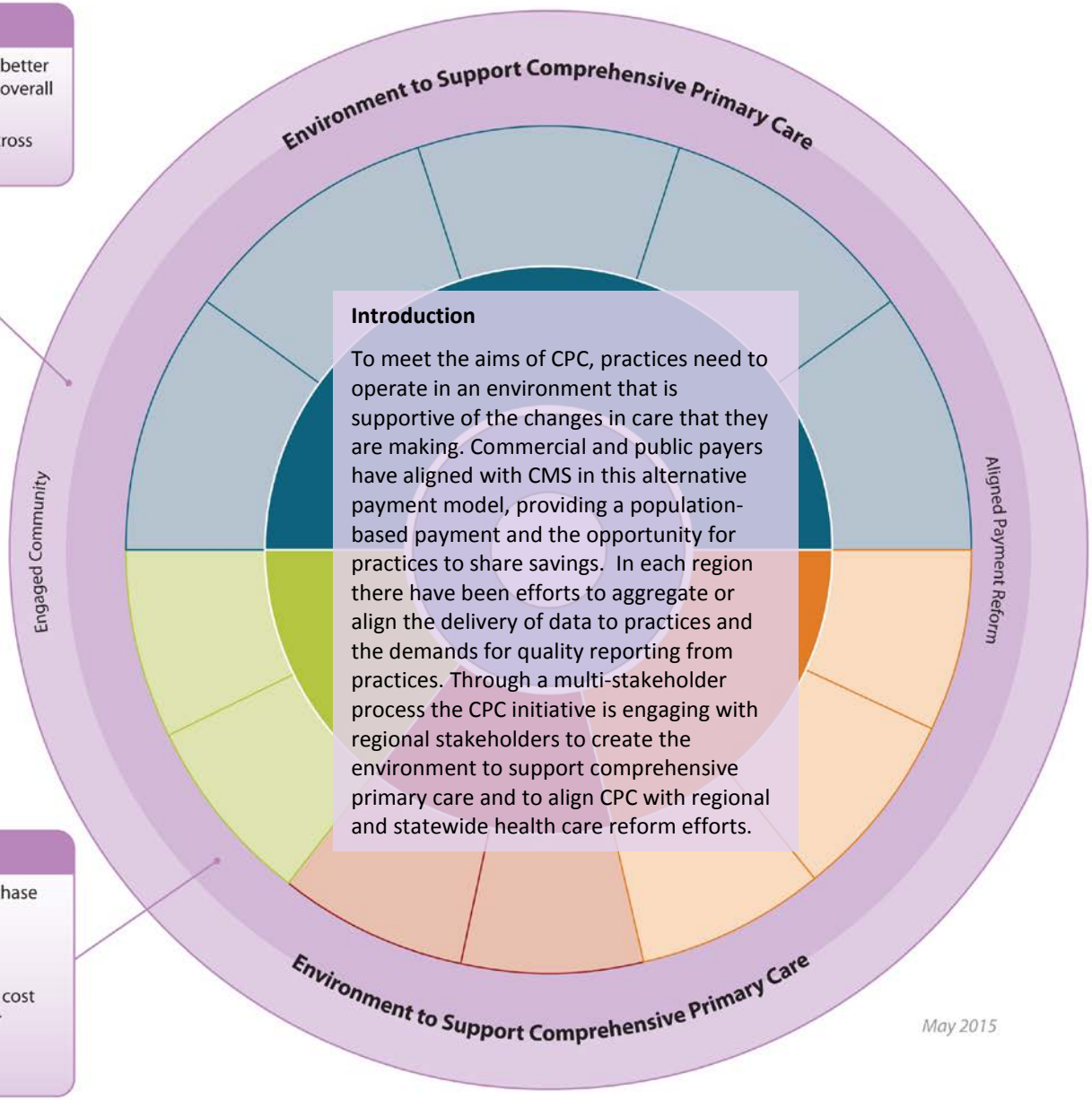
Secondary Driver	Change Concept	Change Tactics (Examples)	Suggested Search Terms to Locate Applicable Resources
4.1 **Continuous Improvement of HIT**	A: Align with the Meaningful Use (MU) program to improve EHR function and capability.	• Use an ONC-certified EHR. • Align practice changes for Comprehensive Primary Care with MU requirements.	• Milestone 9, EMR, meaningful use, ONC
	B: Develop practice capacity for optimal use of EHR	• Identify staff with responsibility for management of EHR capability and function. • Cross-train staff members in key skills in the use of HIT to improve care. • Convene regularly to discuss and improve workflows to optimize use of the EHR. • Engage regularly with EHR vendors about EHR requirements to deliver efficiently the five CPC functions and for EHR-based quality reporting.	• All Milestones, analytic capability, culture of improvement, eCQMs • Milestone 9, EMR, HIMSS, meaningful use, ONC
4.2 **Data Exchange**	A: Enable the exchange of patient information to support care.	• Connect to local health information exchanges, if available. • Develop information exchange processes and care compacts with other service providers with which the practice shares patients. • Use standard documents created by the EHR to routinely share information (e.g., medications, problem, allergies, goals of care, etc.) at time of referral and transition between settings of care. • Use non-clinician workflows to systematically enter structured clinical data from external (e.g., paper and e-fax) sources into the EHR.	• Milestone 2, Milestone 2 action group, care coordination • Milestone 6, Milestone 6 action group, care compacts, care contracts, follow up, HIE, information exchange, medical neighborhood, transitions in care • Milestone 9, meaningful use
4.3 **EHR-Based Quality Reporting**	A: Develop the capability for practice- and panel-level quality measurement and reporting from the EHR.	• Develop capability for practice-level reporting of Clinical Quality Measures derived from the EHR. • Develop capability for panel-level reporting of Clinical Quality Measures derived from the EHR. • Develop capability for electronic transmission of quality reports.	• Milestone 5, analytic capability, CQM, EMR, panel management

Primary Driver – 5.0 Environment to Support Comprehensive Primary Care

Change Concept 5.1

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.



Introduction

To meet the aims of CPC, practices need to operate in an environment that is supportive of the changes in care that they are making. Commercial and public payers have aligned with CMS in this alternative payment model, providing a population-based payment and the opportunity for practices to share savings. In each region there have been efforts to aggregate or align the delivery of data to practices and the demands for quality reporting from practices. Through a multi-stakeholder process the CPC initiative is engaging with regional stakeholders to create the environment to support comprehensive primary care and to align CPC with regional and statewide health care reform efforts.

Change Concept 5.2

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.

Primary Driver – 5.0 Environment to Support Comprehensive Primary Care

Secondary Driver	Change Concept	Change Tactics	Suggested Search Terms to Locate Applicable Resources
5.1 **Engaged Community**	A: Engage stakeholders with an interest in better care, better health outcomes, and lower overall cost of care in support of CPC practices.	• Engage consumers, employers, unions and other regional or local entities in support of CPC practices. • Engage policy-makers at the regional or state level in the work of CPC. • Ensure that other regional or state primary care improvement efforts are aware of and can align with CPC.	• Culture of improvement, payment, population health, revenue, shared savings
	B: Support processes that integrate care across the Medical Neighborhood.	• Engage hospitals, nursing facilities, pharmacies, other ambulatory providers and community-based services in efforts to improve coordination of care.	• Care coordination, medical neighborhood, population health
5.2 **Aligned Payment Reform**	A: Use population-based payment to purchase comprehensive primary care services.	• Prospectively align every member or beneficiary with a primary care provider, care team or practice. • Provide a per-member or beneficiary per-month supplement to fee for services for comprehensive primary care services. • Use a methodology shared with practices to risk adjust per member/beneficiary per month payment. • Align standards for Comprehensive Primary Care services.	• Culture of improvement, payment, population health, shared savings
	B: Provide actionable and timely cost and utilization data to practices.	• Provide at least quarterly reports of timely data, by provider and practice, of services received by beneficiaries from outside of the primary care practice. • Notify providers and practices of ER visits and admissions, as soon as possible. • Engage with practices to improve the usability and functionality of data reports.	• Analytic capability, high risk, medical neighborhood, population management,
	C: Reward practice actions to reduce total cost of care through shared savings or other mechanism.	• Use shared savings or similar methodology to reward achievement of better care, better health outcomes and lower total cost of care. • Provide regular data that practices can use to guide practice changes to create shared savings. • Seek alignment between payment incentives and contract terms and the five Comprehensive Primary Care functions.	• Analytic capability, outcome measures, payment, revenue, shared savings
	D: Align quality measures.	• Seek alignment on all three types of CPC quality measures (quality of care, patient experience and cost of care) with CMS and other major payers in the market.	• Clinical quality measures, expense, patient experience, revenue, shared savings