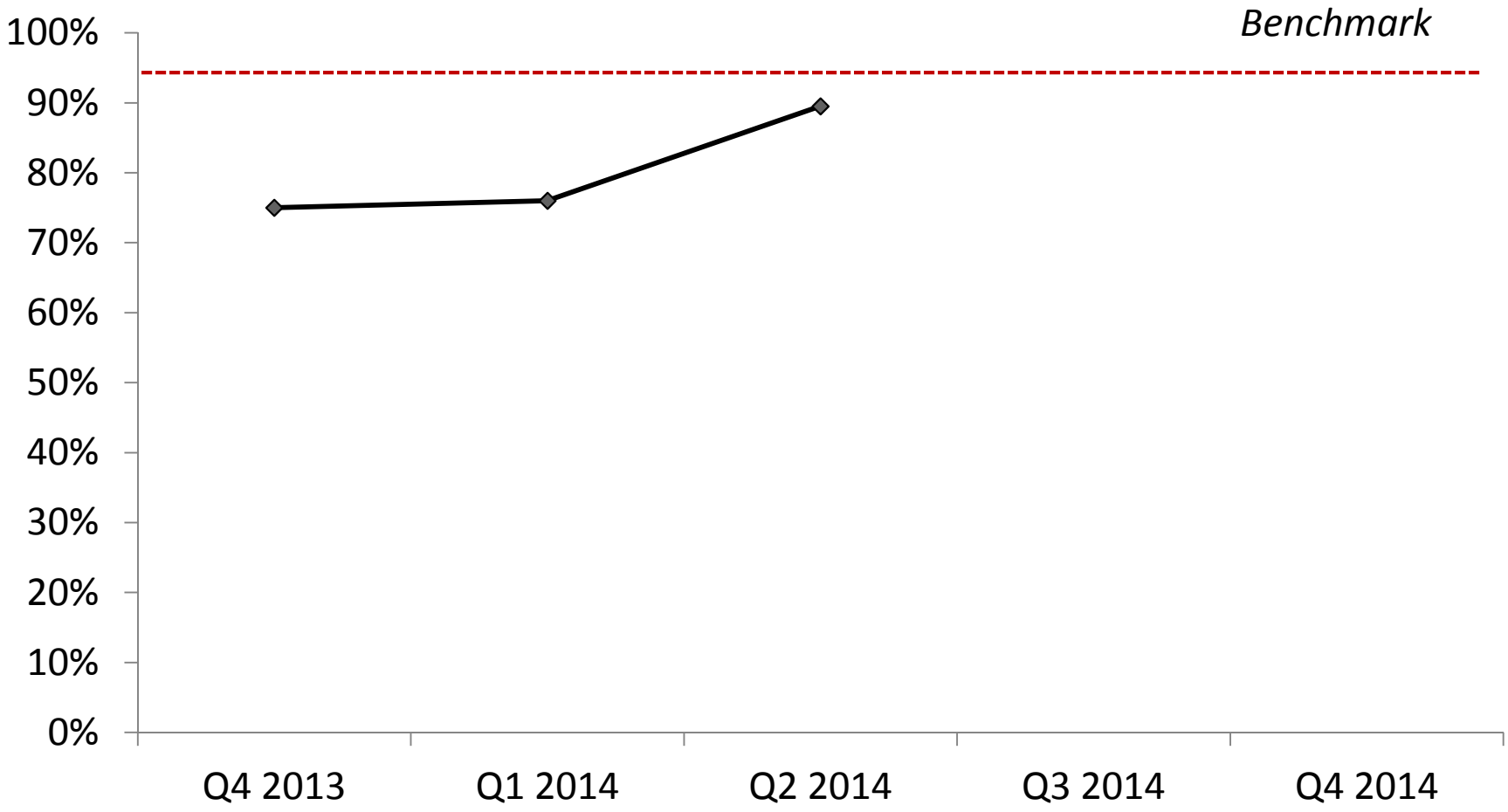
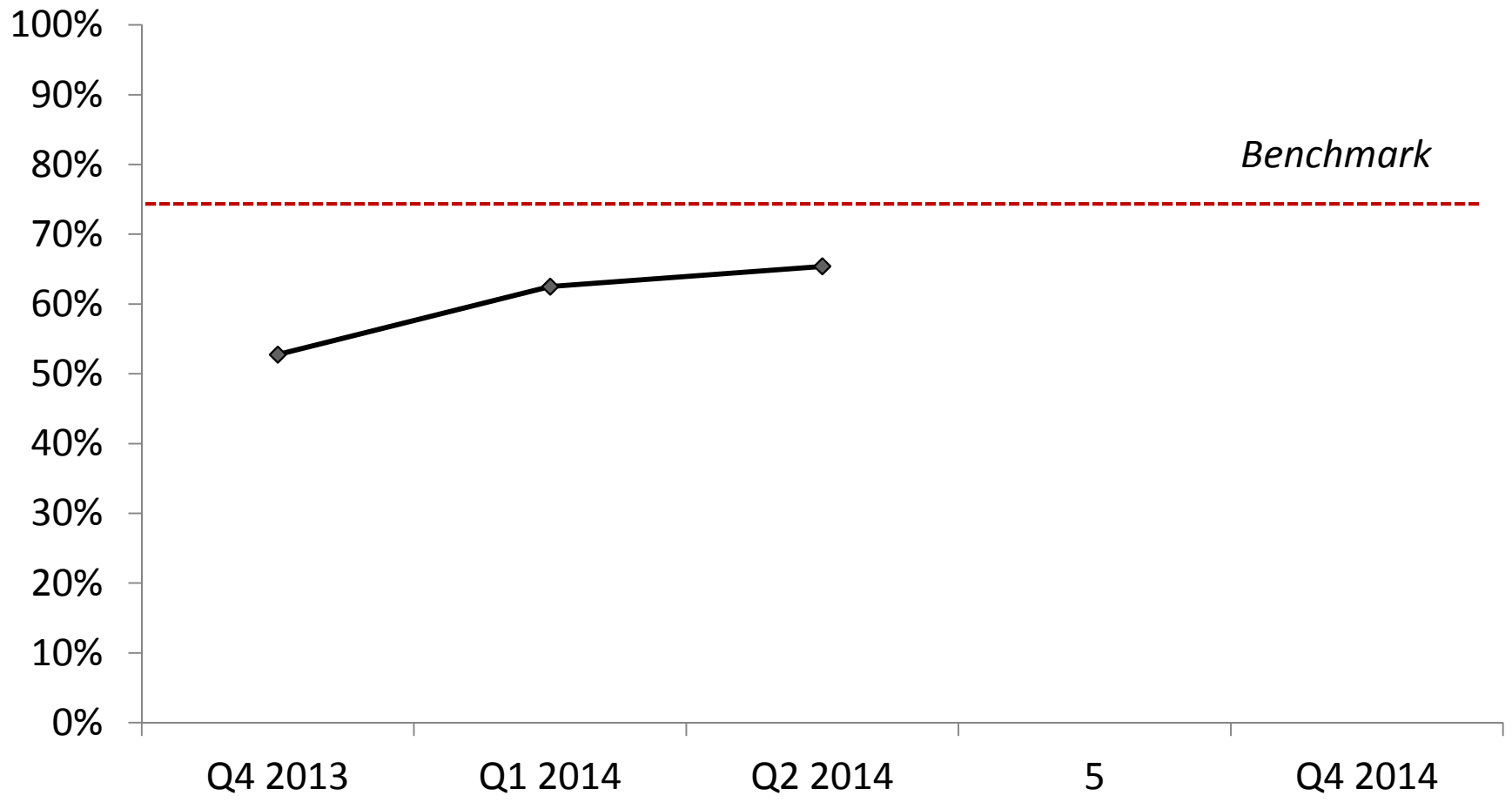
CPCI Milestone 2: Care Management of High Risk Patients

1. Maintain at least 95% empanelment to provider and care teams.
2. Risk stratify all patients, achieving risk stratification of at least 75% of empanelled patients.
3. Provide care management to at least 80% of highest risk patients
4. Implement integration of behavioral health for high risk patients.

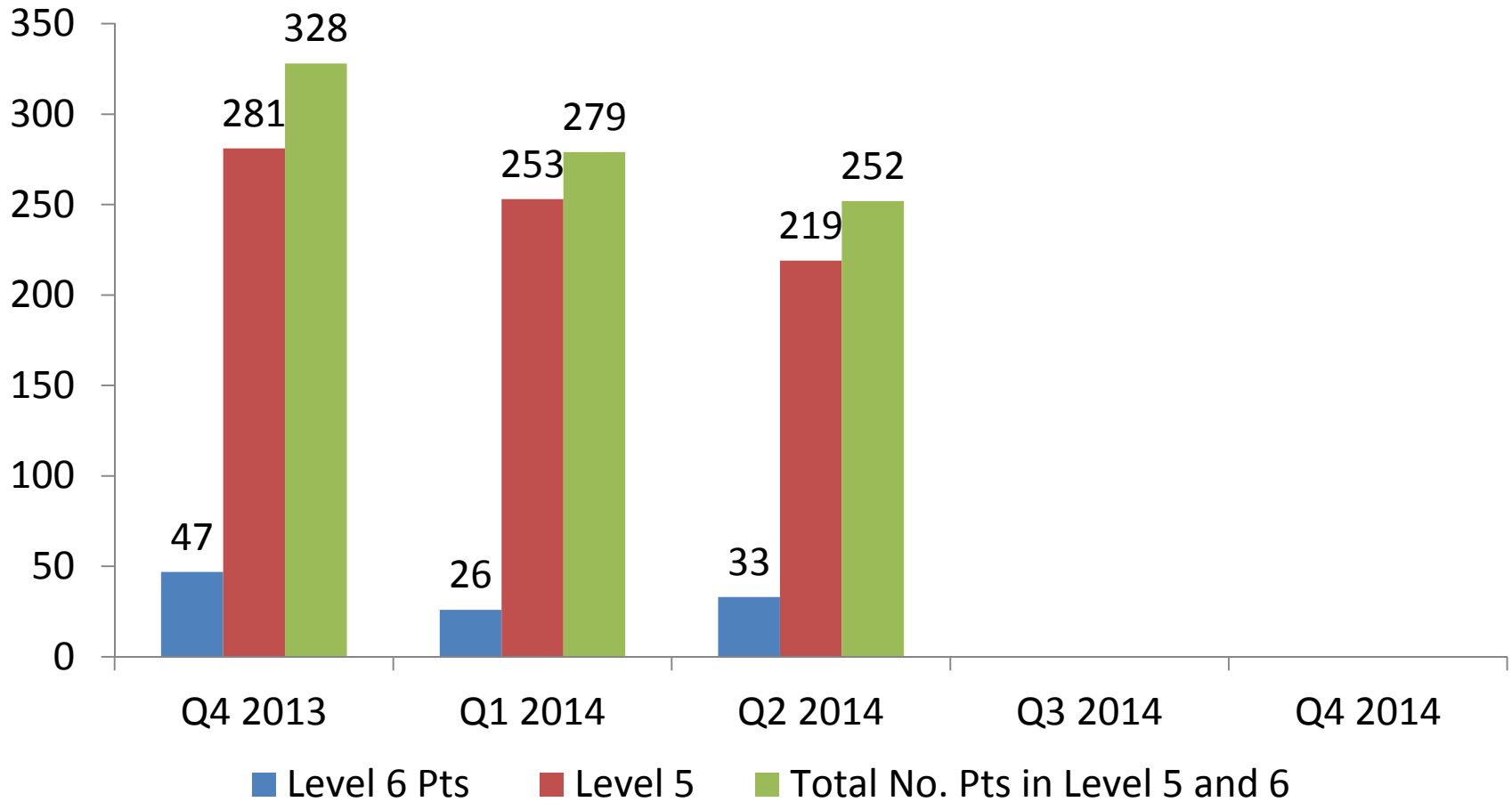
Increase in empanelment to 89.5% in Q2



Percent of Pts Who Have Been Risk Stratified Increases From Q4 2013 to Q1 2014

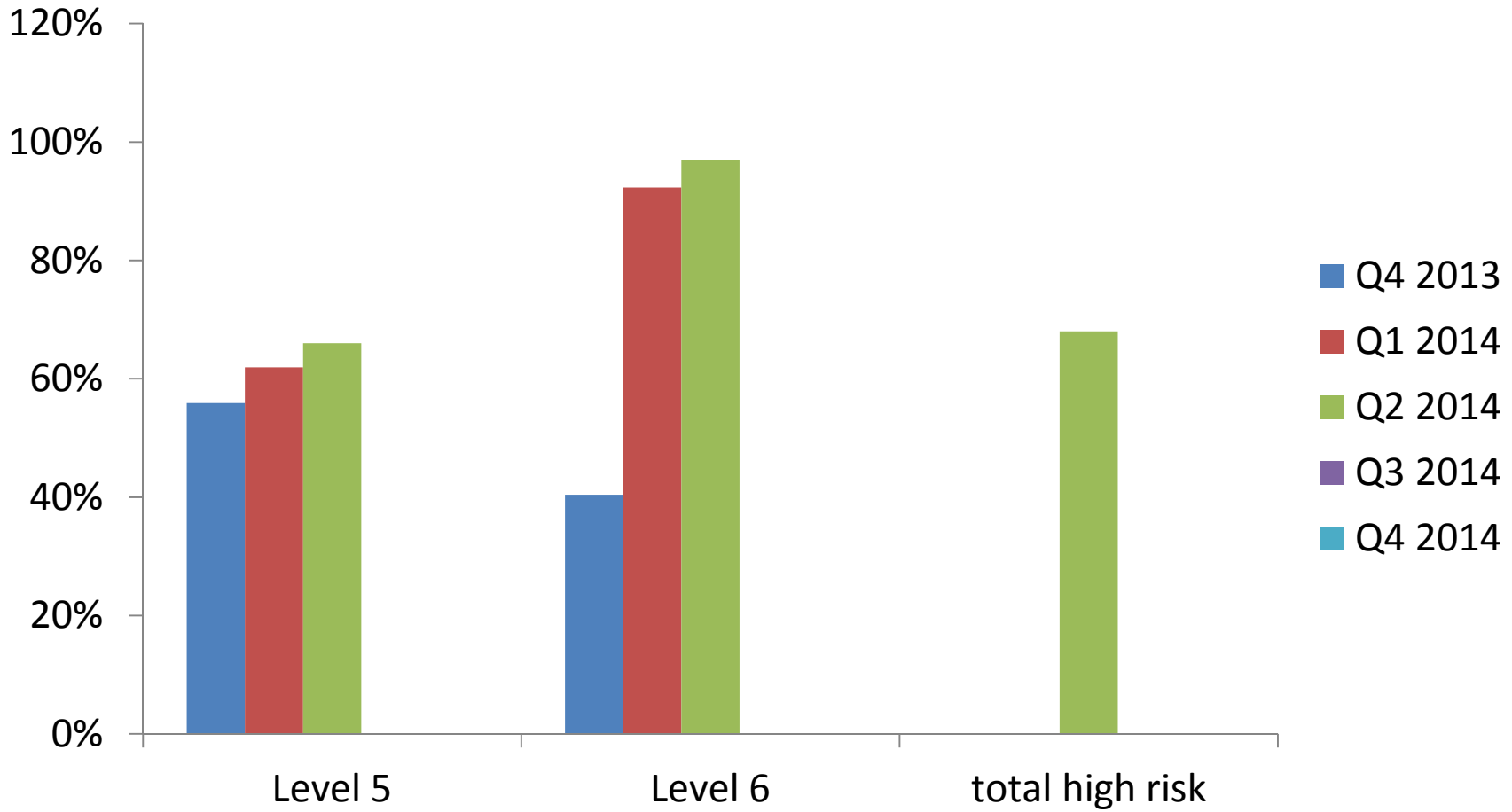


High-Risk Patient Risk Stratification Statistics



Reason for the decrease in total number of high-risk patients may be related in part to ongoing refinement of data reporting from EMR.
Reason for the decreases in number of patients in each risk level may be related in part to ongoing re-stratification.

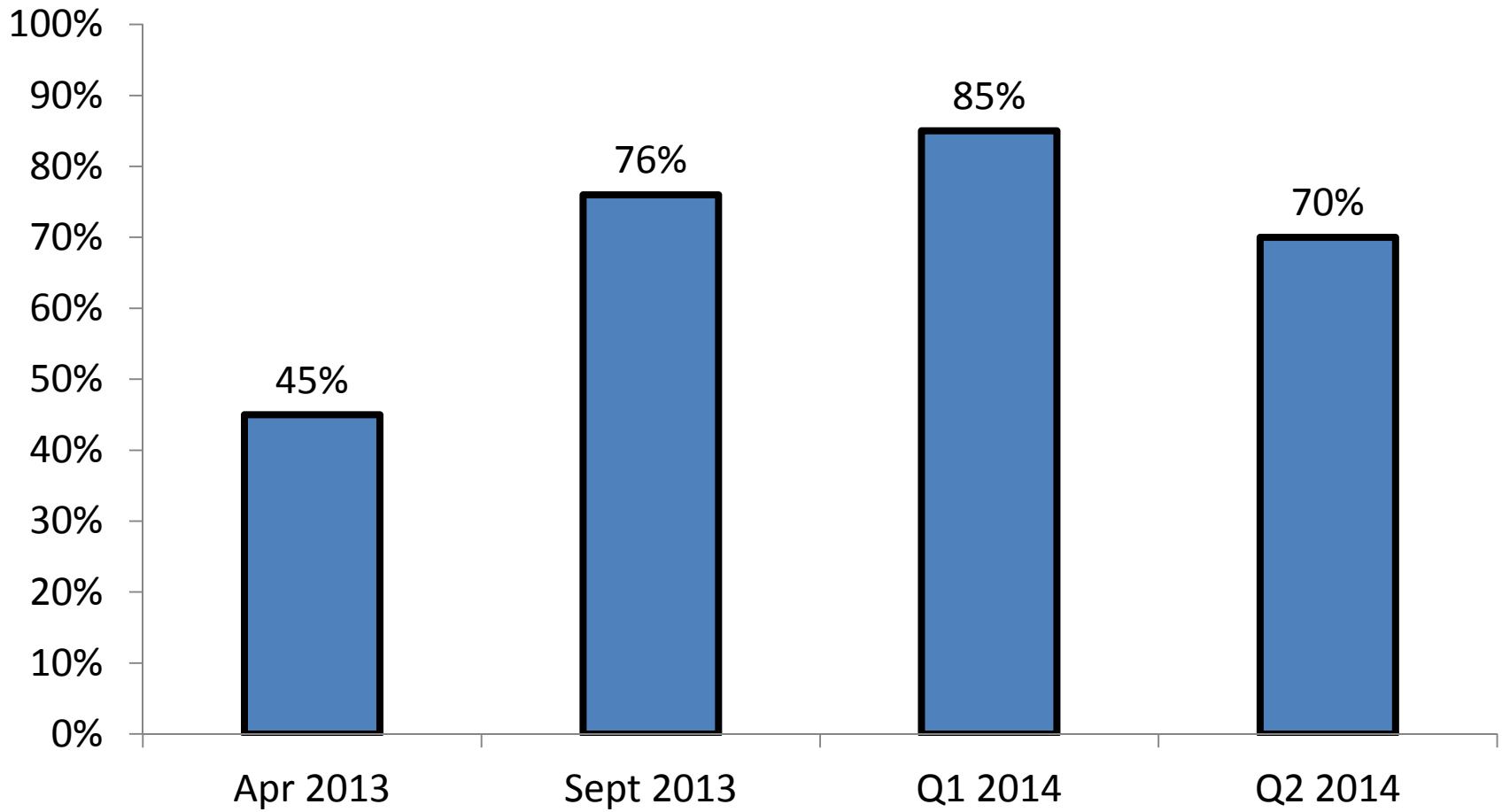
Percent of High-Risk Pts Receiving Care Mgmt Increases From Q4 2013 to Q2 2014



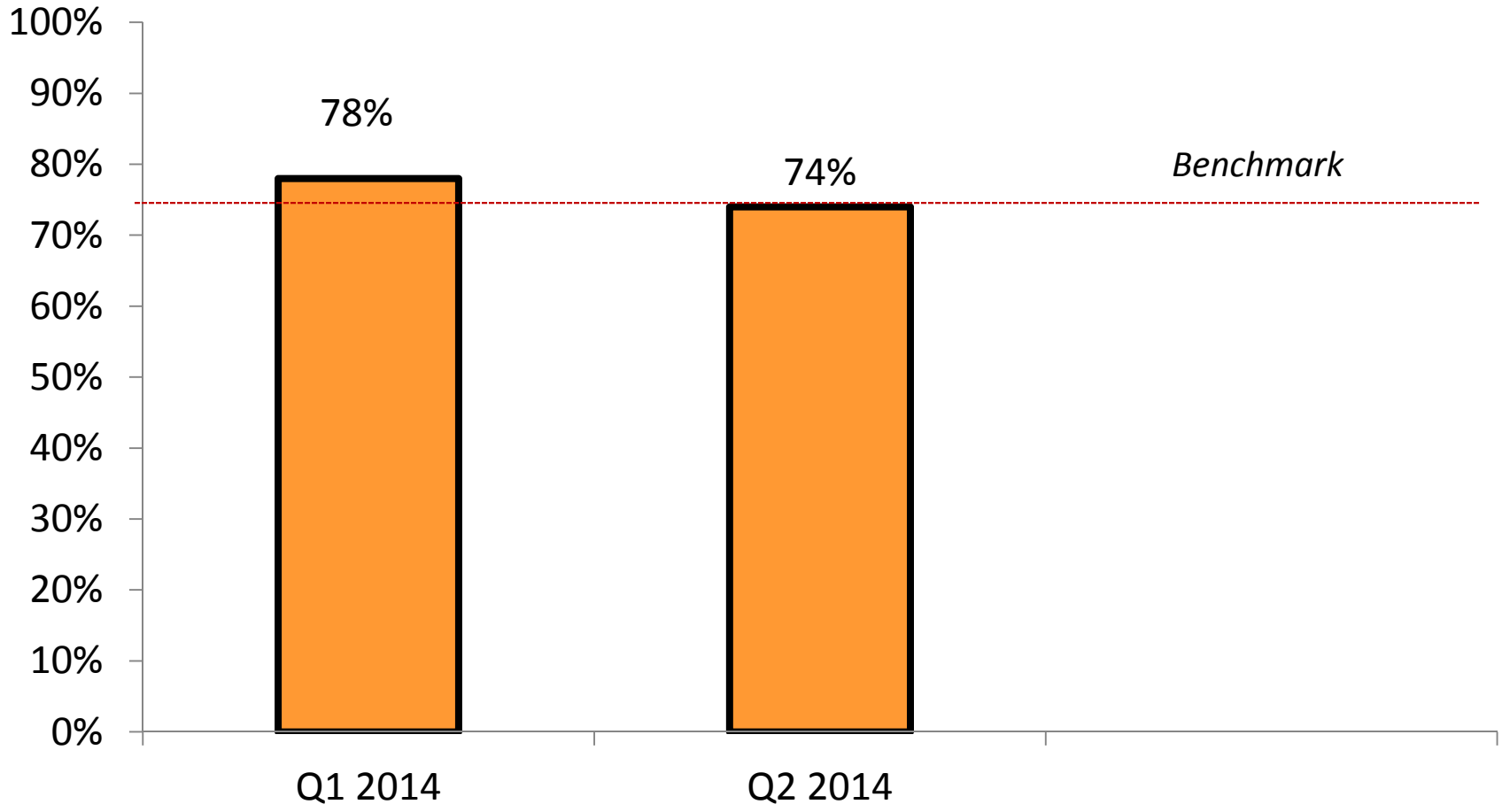
CPCI Milestone 6: Care Coordination Across the Medical Neighborhood

1. Track % of patients with ED visits who received a follow up phone call within one week.
2. Contact at least 75% of patients who were hospitalized in target hospital(s) within 72 hours.

ER follow-up contact- within 7 days



Hospital discharge follow up within 72 hours



*Percent of patients who were hospitalized in target hospital (RWJUH) within 72 hours.