Healthier Washington Medicaid Transformation

Accountable Communities of Health

Semi-annual report Template

Reporting Period: July 1, 2018 – December 31, 2018

January 31, 2019

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Attachments:

- Semi-annual report workbook
- Organizational self-assessment of internal controls and risks: (GCACH.SAR2.Attachment10.1.31.19)

Semi-annual report information and submission instructions

Purpose and objectives of ACH semi-annual reporting

As required by the Healthier Washington Medicaid Transformation's Special Terms and Conditions, Accountable Communities of Health (ACHs) must submit semi-annual reports to report on project implementation and progress milestones. ACHs will complete a standardized semi-annual report template and workbook developed by HCA. The template will evolve over time to capture relevant information and to focus on required milestones for each reporting period. ACHs must submit reports as follows each Demonstration Year (DY):

- **July 31** for the reporting period January 1 through June 30
- **January 31** for the reporting period July 1 through December 31

Semi-annual reporting is one element of ACH Pay-for-Reporting (P4R) requirements. The purpose of the semi-annual reporting is to collect necessary information to evaluate ACH project progress against milestones, based on approved Project Plans and corresponding Implementation Plans. HCA and the IA will review semi-annual report submissions.

The ACH may be called upon to share additional information that supports the responses submitted at any subsequent time for purposes of monitoring and auditing, or general follow-up and learning discussions with the state (HCA), the Independent Assessor (IA) and/or the Independent External Evaluator (IEE).

Reporting requirements

The semi-annual report template for this reporting period includes four sections as outlined in the table below. With one exception, the reporting period for this semi-annual report covers July 1, 2018 to December 31, 2018.[1] Sections 1 and 2 instruct ACHs to report on and attest to the completion of required milestones scheduled to occur by DY 2, Quarter 4 per the Medicaid Transformation Toolkit. Sections 3 and 4 requests information to satisfy ongoing reporting requirements to inform the Independent Assessor and HCA of organizational updates and project implementation progress.

Note: Each section in the semi-annual report contains questions regarding the regional transformation work completed during the reporting period. ACHs are required to provide responses that reflect the regional transformation work completed by either:

- The ACH as an organization
- The ACH's partnering providers
- The ACH and its partnering providers

Please read each prompt carefully for instructions as to how the ACH should respond.

[1] The reporting period for Value-based Payment (VBP) milestones covers the full calendar year, January 1 through December 31, 2018.

ACH semi-annual report 2		
Section	**Reporting period**	**Sub-section description**
Section 1. Required milestone reporting (VBP Incentives)	DY 2, Q1-Q4	Milestone: Inform providers of value-based payment (VBP) readiness tools to assist their move toward value-based care
		Milestone: Connect providers to training and/or technical assistance offered through HCA, the Practice Transformation Hub, Managed Care Organizations (MCOs), and/or the ACH
		Milestone: Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey
		Milestone: Support providers to develop strategies to move toward value-based care
Section 2. Required milestone reporting (Project Incentives)	DY 2, Q3-Q4	Milestone: Support regional transition to integrated managed care (2020 regions only)
		Milestone: Identified HUB lead entity and description of HUB lead entity qualifications (Project 2B only)
		Milestone: Engagement/support of Independent External Evaluator (IEE) activities
Section 3. Standard reporting requirements (Project Incentives)	DY 2, Q3-Q4	ACH organizational updates
		Tribal engagement and collaboration
		Integrated managed care status update (early- and mid-adopters only)
		Project implementation status update
		Partnering provider engagement
		Community engagement and health equity
		Budget and funds flow
Section 4. Provider roster (Project Incentives)	DY 2, Q3-Q4	Completion/maintenance of partnering provider roster
Section 5. Integrated managed care implementation (Integration Incentives)	N/A	Milestone: Implementation of integrated managed care (mid-adopters only)

Key terms

The terms below are used in the semi-annual report and should be referenced by the ACH when developing responses.

1. **Community engagement**: Outreach to and collaboration with organizations or

individuals, including Medicaid beneficiaries, that are not formally participating in project activities and are not receiving direct DSRIP funding but are important to the success of the ACH's projects.

2. **Health equity**: Reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.[2]
3. **Integrated managed care:**
    a. **Early-adopter:** Refers to ACH regions implementing integrated managed care prior to January 1, 2019.
    b. **2020 adopter:** Refers to ACH regions implementing integrated managed care by January 1, 2020.
    c. **Mid-adopter:** Refers to ACH regions implementing integrated managed care on January 1, 2019.
4. **Key staff position**: Position within the overall organizational structure established by the ACH to reflect capability to make decisions and be accountable for the following five areas: Financial, Clinical, Community, Data, and Program Management and Strategy Development.
5. **Partnering provider**: Traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH's projects. Traditional Medicaid providers are traditionally reimbursed by Medicaid; non-traditional Medicaid providers are not traditionally reimbursed by Medicaid.
6. **Project areas:** The eight Medicaid Transformation projects that ACHs can implement.
7. **Project Portfolio**: The full set of project areas an ACH has chosen to implement.

Achievement Values

Throughout the transformation, each ACH can earn Achievement Values (AVs), which are point values assigned to the following:

1. Reporting on project implementation progress (Pay-for-Reporting, or P4R).
2. Performance on outcome metrics for an associated payment period (Pay-for-Performance, or P4P).

ACHs can earn AVs by providing evidence of completion of reporting requirements and demonstrating performance on outcome metrics. The amount of incentive funding paid to an ACH will be based on the number of earned AVs out of total possible AVs for a given payment period.

[2] *Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What Is Health Equity? And What Difference Does a Definition Make? Princeton, NJ: Robert Wood Johnson Foundation, 2017. Accessible at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf437393.*

All possible earned incentives for the second semi-annual report are associated with P4R. The required P4R deliverables and milestones for the second semi-annual reporting period are identified in the table below.

Deliverable/Milestone	One-time / Recurrent	Reporting Period	AVs
Section 1. Required milestone reporting (VBP Incentives)			
Milestone: Inform providers of VBP readiness tools to assist their move toward value-based care	One-time	DY 2, Q1-Q4	1.0
Milestone: Connect providers to training and/or technical assistance offered through HCA, the Practice Transformation Hub, MCOs, and/or the ACH	One-time	DY 2, Q1-Q4	1.0
Milestone: Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey	One-time	DY 2, Q1-Q4	1.0
Milestone: Support providers to develop strategies to move toward value-based care	One-time	DY 2, Q1-Q4	1.0
Section 2. Required milestone reporting (Project Incentives)			
Milestone: Support regional transition to integrated managed care (2020 regions only)	One-time	DY 2, Q3-Q4	1.0
Milestone: Identified HUB lead entity and description of HUB lead entity qualifications (Project 2B only)	One-time	DY 2, Q3-Q4	1.0
Milestone: Engagement/support of Independent External Evaluator (IEE) activities	Recurrent	DY 2, Q3-Q4	1.0 per project in project portfolio
Section 3. Standard reporting requirements (Project Incentives)			
Deliverable: Complete and timely submission of SAR. *Note: All non-milestone, standard reporting requirements are a part of the SAR 1.0 AV.*	Recurrent	DY 2, Q3-Q4	1.0 per project in project portfolio
Section 4. Provider roster (Project Incentives)			
Deliverable: Completion/maintenance of partnering provider roster	Recurrent	DY 2, Q3-Q4	1.0 per project in project portfolio
Section 5. Integrated managed care implementation (Integration Incentives)			
Milestone: Implementation of integrated managed care (mid-adopters only)	One-time	N/A	N/A

Semi-annual report submission instructions

ACHs must submit their completed semi-annual reports to the Independent Assessor **no later than January 31, 2019 at 3:00p.m. PST.**

Washington Collaboration, Performance, and Analytics System (WA CPAS)

ACHs must submit their semi-annual reports through the WA CPAS, which can be found at https://cpaswa.mslc.com/.

ACHs must upload the Semi-Annual Report, workbook, and any attachments to the sub-folder titled "Semi-Annual Report 2 – January 31, 2019."

The folder path in the ACH's directory is:

Semi-Annual Reports → Semi-Annual Report 2 – January 31, 2019.

Please see the WA CPAS User Guide provided in fall 2017, and available on the CPAS website, for further detail on document submission.

File format

ACHs must respond to all items in the Microsoft Word semi-annual report template and the Microsoft Excel semi-annual report workbook based on the individual question instruction. ACHs are strongly encouraged to be concise in their responses.

ACHs must include all required attachments, and label and make reference to the attachments in their responses where applicable. Additional attachments may only substantiate, not substitute for, a response to a specific question. HCA and the IA reserve the right not to review attachments beyond those that are required or recommended.

Files should be submitted in Microsoft Word and Microsoft Excel or a searchable PDF format. Below are examples of the file naming conventions that ACHs should use:

- *Main Report or Full PDF:* ACH Name.SAR2 Report. 1.31.19
- *Excel Workbook:* ACH Name. SAR2 Workbook. 1.31.19
- *Attachments:* ACH Name.SAR2 Attachment X. 1.31.19

Note that all submitted materials will be posted publicly to HCA's Medicaid Transformation resources webpage.[3]

[3] https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-resources

Semi-annual report submission and assessment timeline

Below is a high-level timeline for assessment of the semi-annual reports for reporting period July 1, 2018 – December 31, 2018.

ACH semi-annual Report 2 – submission and assessment timeline			
No.	**Activity**	**Responsible party**	**Anticipated timeframe**
1.	Distribute semi-annual report template and workbook for reporting period 2 to ACHs	HCA	August 2018
2.	Submit semi-annual reports	ACHs	Jan 31, 2019
3.	Conduct assessment of reports	IA	Feb 1-25, 2019
4.	If needed, issue information request to ACHs within 30 calendar days of report due date	IA	Feb 25-March 2, 2019
5.	If needed, respond to information request within 15 calendar days of receipt	ACHs	Feb 26-March 17, 2019
6.	If needed, review additional information within 15 calendar days of receipt	IA	Feb 27-April 1, 2019
7.	Issue findings to HCA for approval	IA	End of Q2

Contact information

Questions about the semi-annual report template, submission, and assessment process should be directed to WADSRIP@mslc.com.

ACH contact information

Provide contact information for the primary ACH representative. The primary contact will be used for all correspondence relating to the ACH's semi-annual report. If secondary contacts should be included in communications, please also include their information.

ACH name:	Greater Columbia Accountable Community of Health
Primary contact name **Phone number** **E-mail address**	Carol Moser 509-851-7601 cmoser@gcach.org
Secondary contact name **Phone number** **E-mail address**	Wes Luckey 509-851-7784 wluckey@gcach.org

Section 1. Required milestone reporting (VBP Incentives)

This section outlines questions specific to **value-based payment (VBP) milestones** in support of the objectives of Domain 1 (Health and Community Systems Capacity Building), to be completed by DY 2, Q4.

Note: For VBP milestones only, the reporting period covers the full calendar year (January 1 through December 31, 2018). Where applicable, ACHs may use examples or descriptions of activities that may have been included in previously submitted reporting deliverables. Regardless, activities must reflect efforts that occurred during DY 2.

A. Milestone: Inform providers of VBP readiness tools to assist their move toward value-based care.

1. **Attestation:** The ACH has informed providers of and/or disseminated readiness tools to assist providers to move toward value-based care in the region.

   Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

2. If the ACH checked "No" in item A.1, provide the ACH's rationale for not informing providers of and/or disseminating readiness tools. If the ACH checked "Yes" in item A.1, respond "Not applicable."

   ACH response:

   Not applicable.

3. In the table below, list three examples of how the ACH has informed the following providers of VBP readiness tools: 1) providers with low VBP knowledge or significant barriers/challenges, 2) small providers (25 full time equivalents (FTEs) or fewer), and 3) behavioral health providers.

VBP readiness tool dissemination activities			
Intended audience	**Communication method**	**Date**	**Specific tools provided**
Provider with low VBP knowledge	Direct convening of community stakeholders and partnering providers during our January Leadership Council meeting	January 18, 2018	The GCACH Leadership Council received presentations from Jennifer Bresnick, a publisher with HealthITAnalytics, who presented, *Embracing Population Health Management to Prepare for Value-*

VBP readiness tool dissemination activities			
Intended audience	**Communication method**	**Date**	**Specific tools provided**
			Based Care, and Thomas Isaac, MD, MPH, MBA, Medical Director for Quality with Atrius Health, who gave a population health overview. Ms. Bresnick discussed the components of Population Health Management (e.g. registries and risk stratification) and how these will drive provider readiness and success under VBP. Dr. Isaac presented on the programs in place at Atrius Health that are allowing them to successfully contract under value-based payment arrangements.
Provider with low VBP knowledge	Direct convening of community stakeholders and partnering providers during our November 2018 Leadership Council meeting	November 15, 2018	1. JD Fischer, a Senior Health Policy Analyst at the Health Care Authority, made a presentation to the GCACH Leadership Council on Value-based Payment. The presentation included a description of what is driving VBP, a definition of VBP, the goals behind payment reform, and what is needed in terms of Practice Transformation for provider organizations to be successful under payment reform. 2. At the same Leadership Council meeting, there was also a facilitated panel discussion that included representatives from our partnering provider organizations (Providence, Signal Health and Yakima Neighborhood Health Services) and from the MCOs (Amerigroup and CHPW). Each representative on the panel responded to questions that related to provider readiness for VBP and MCO's role in Washington State with VBP.

VBP readiness tool dissemination activities			
Intended audience	**Communication method**	**Date**	**Specific tools provided**
Small provider	The GCACH Practice Transformation Toolkit and Practice Transformation Workbook	December 2018	The GCACH has crafted a comprehensive and detailed toolkit and workbook for providers undergoing Practice Transformation. The toolkit and workbook borrow from the CMS' Comprehensive Primary Care Implementation and Milestone Reporting Summary Guide, which provides guidance for providers on how to achieve success with the components included under the Primary Care Medical Home Model: • Empanelment • Risk Stratification • Care Management • Bi-Directional Integration • Self-Management Support • Medication Management • 24/7 Access • Share Decision Making • Care Coordination • Clinical Quality Measurement • Health Information Technology Each section of the Toolkit also contains resources that can be referenced for further education. Achieving Milestone deliverables within the Toolkit will be linked to change plans and tied to provider incentive payments.
Behavioral health provider	Behavioral Health Agency Transformation Intensives: Day 2- Preparing for Value-Based Payment	August 9, 2018	In August 2018, the GCACH facilitated Behavioral Health Agencies linked to Integrated Managed Care and Practice Transformation to travel to Spokane to participate in a learning session around Value-Based Payment, sponsored by Qualis Health, WA DOH and Healthier Washington. At the

VBP readiness tool dissemination activities			
Intended audience	**Communication method**	**Date**	**Specific tools provided**
			day-long meeting, a number of presenters spoke on value-based payment and strategies needed for success under VBP. The GCACH facilitated local BH providers to participate and was part of the organizing group.

4. **Attestation:** The ACH conducted an assessment of provider VBP readiness during DY 2.

   Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

5. If the ACH checked "No" in item A. 4 provide the ACH's rationale for not completing assessments of provider VBP readiness during DY 2. If the ACH checked "Yes" in item A.4, respond "Not applicable."

   ACH response:

   Not applicable.

B. Milestone: Connect providers to training and/or technical assistance offered through HCA, the Practice Transformation Hub, Managed Care Organizations (MCOs), and/or the ACH.

1. In the table below, list three examples of how the ACH connected providers to training and/or technical assistance (TA) offered through HCA, the Practice Transformation Hub, MCOs, and/or the ACH or ACH contractors. Provide examples, including the recipients of the training and/or TA, identified needs, and specific resource(s) used.

Connecting providers to training and/or technical assistance		
Recipient of training/TA	**Identified needs**	**Resources used**
Practice Transformation Workgroup (PTW) Meeting 5-31-18	PTW needed to understand why the Patient Centered Medical Home model of care is the best approach to value-based contracting	Presentation by GCACH Director of Practice Transformation using the following resources: https://www.openminds.com/market-intelligence/executive-briefings/value-based-reimbursement-numbers/ https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/physician-alignment-strategy-health-system-executive-survey-findings.html *https://revcycleintelligence.com/features/what-is-value-based-care-what-it-means-for-providers*
GCACH Leadership Council attendees – January 2018	There was a need within the Greater Columbia region to increase the understanding of population health management.	Jennifer Bresnick, Director of Editorial at Xtelligent Media, LLC and Lead Editor of HealthITAnalytics.com conducted a webinar on "Provider-Led Population Health Management". Her presentation focused on the evolving definition and challenges related to Population Health, essential elements needed for change, and collaborations and partnerships that support Population Health Management. Thomas Isaac, Medical Director of Atrius Health in Massachusetts, presented "Atrius Population Health Overview". He discussed strategies to managing patient cohorts linked to risk based contracting and discussed the roles of Population Management Coordinators within team-based care. Following the presentations there was a full group discussion, facilitated by Wes Luckey and Patrick Jones. Participants shared their positive feedback, potential barriers and major

Connecting providers to training and/or technical assistance		
Recipient of training/TA	**Identified needs**	**Resources used**
		takeaways regarding population health management.
GCACH Leadership Council attendees – November 2018	During site visits and communication with practices in the Greater Columbia region, staff identified that there was a need for further training on value-based payment. This need was common among primary care practices and behavioral health agencies.	Training was provided by J.D. Fischer, from HCA, on 'The What, Why, and How of Value-Based Purchasing'. Following that training, there was a panel discussion on Value-Based Payment. Panel members included • Shawnie Haas, President and CEO of Signal Health • Rob Watilo, CSO, Southeast Washington Region at Providence Health & Services • Rhonda Hauff, Chief Operating Officer and Deputy CEO, Yakima • Caitlin Safford, Director of External Affairs and Community Development, Amerigroup Washington • Kat Latet, Manager of Health System Innovation, Community Health Plan of Washington
IMC BH Providers	Knowledge regarding VBP contracting/how to maximize reimbursements. To ensure that all services are submitted to the appropriate payers and they have been accepted, it is important to institute reconciliation processes at various points in time.	*Billing and Information Technology: A Toolkit for Behavioral Health Agencies*, SAMHSA HRSA, Preparing for VBP series

C. Milestone: Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey.

1. In the table below, list three examples of the ACH's efforts to support completion of the state's 2018 provider VBP survey. The ACH should indicate any new tactics, compared to tactics employed in prior years, to increase participation.

State provider VBP survey communication activities			
Tactic		**Incentives offered? (Yes/No)**	**New tactic? (Yes/No)**
Contractual expectation of provider	Individuals on the Practice Transformation Workgroup (PTW) were incented $15,000 for their participation in this workgroup where VBP was a common topic of discussion. President of GCACH was on the MVP Action Team and a part of the PTW.	Yes	Yes
Post survey link to ACH website; email communication to broad distribution list	HCA-VBP Survey link promoted on GCACH Website. HCA-VBP Survey promoted in August and September 2018 GCACH newsletters. Distribution of GCACH is about 650 individuals and organizations.	No	Yes
Individual communication with providers	Emails sent to 85 targeted providers on August 14, and PCMH cohort (23 providers) on August 31st	No	Yes

D. Milestone: Support providers to develop strategies to move toward value-based care.

1. In the table below, provide three examples of how the ACH has supported providers to develop strategies to move toward value-based care. Examples of ACH support include direct TA or training, provision of TA or training resources, monetary support, development of an action plan, etc. The ACH must provide an example for three unique provider types: 1) providers with low VBP knowledge or significant barriers/challenges, 2) small providers (25 FTEs or fewer), and 3) behavioral health providers.

ACH provider support activities				
Provider type	**Provider needs (e.g., education, infrastructure investment)**	**Supportive activities**	**Description of action plan: How provider needs will be addressed (if applicable)**	**Key milestones achieved**
Provider with low VBP knowledge	The smaller BH agencies had limited experience with VBP contracting.	BH agencies transitioning to fully integrated managed care received funding for infrastructure investment (population health management tools), education and individual technical assistance to support transition.	The Practice Transformation Implementation Workplan (PTIW) identifies individual needs and goals, training needs for the duration of the MTP.	All providers had a MeHAF assessment, completed PTIWS, and received the readiness guide which looks at capability for transitioning from BHO billing to the MCO billing platform.
Small provider	The Health Center, a small school -based clinic needed training on empanelment and risk stratification.	Practice Navigators provided education on empanelment and technical assistance to show how their EHR, Practice Fusion, was capable of empanelment and risk stratification.	The need was identified during the completion of the Patient Centered Medical Home Assessment (PCMH-A) and Maine Health Access Foundation (MeHAF). The need was documented in the Practice Transformation Implementation Workplan (PTIW), which serves as the change plan for an organization.	The Health Center has implemented risk stratification and empanelment for their practice.
Behavioral health provider	Behavioral Health Agencies needed information on how to structure a VBP contract, especially since all MCO use different reporting	Provide Education to the Behavioral Health providers on preparing for Value-Base Payments	Provided technical assistance to individual providers for testing billing claims. Provided a contingency plan in the event claims were delayed, gave each	All BH agencies have received full payment for their contracts, have signed PTIWs, completed assessments, and contingency plans. BH

ACH provider support activities				
Provider type	**Provider needs (e.g., education, infrastructure investment)**	**Supportive activities**	**Description of action plan: How provider needs will be addressed (if applicable)**	**Key milestones achieved**
	platforms and mapping of claims. Needed to understand how to bill Indian Health Services as they use a different platform for claims mapping.		Provider a point of contact for each MCO for billing issues and technical assistance.	agencies receiving TA and education as they transition to managed care.

Section 2. Required milestone reporting (Project Incentives)

This section outlines questions specific to **project milestones** in support of the objectives outlined in the Medicaid Transformation Project Toolkit by DY 2, Q4. This section will vary each semi-annual reporting period based on the required milestones for the associated reporting period.

A. Milestone: Support regional transition to integrated managed care (2020 regions only)

1. **Attestation:** The ACH engaged and convened county commissioners, tribal governments, MCOs, behavioral health and primary care providers, and other critical partners to discuss a process and timeline for regional transition to integrated managed care. Place an "X" in the appropriate box.

   Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No

   a. If the ACH checked "No" in item A.1, provide the rationale for having not discussed a process and timeline for regional transition to integrated managed care. Describe the steps and associated timelines the ACH will take to complete this milestone. If the ACH checked "Yes," to item E.1 respond "Not applicable."

      ACH response:

2. **Attestation.** The ACH, county commissioners, tribal governments, MCOs, behavioral health and primary care providers, and other critical partners developed a plan and

description of steps that need to occur for regional transition to integrated managed care. Place an "X" in the appropriate box.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No

a. If the ACH checked "No" in item A.2, provide the rationale for having not developed a plan for regional transition to integrated managed care. Describe the steps and associated timelines the ACH will take to complete this milestone. If the ACH checked "Yes," to item E.1 respond "Not applicable."

ACH response:

3. Has the region made progress during the reporting period to establish an early warning system (EWS)?
   a. If yes, describe the region's plan to establish an EWS Workgroup, including:
      i. Which organization will lead the workgroup
      ii. Estimated date for establishing the workgroup
      iii. An estimate of the number and type workgroup participants
   b. If no, provide the rationale for not establishing an EWS. How has the ACH identified the process to monitor the transition to IMC and identify transition-related issues for resolution?

   ACH response:

4. Describe the region's efforts to establish a communications workgroup, including:
      i. Which organization will lead the workgroup
      ii. Estimated date for establishing the workgroup
      iii. An estimate of the number and type of workgroup participants

   ACH response:

5. Describe the region's efforts to establish a provider readiness/technical assistance (TA) workgroup, including:
      i. Which organization will lead the workgroup
      ii. Estimated date for establishing the workgroup
      iii. An estimate of the number and type of workgroup participants

ACH response:

6. What provider readiness and/or TA needs has the ACH identified for Medicaid behavioral health providers transitioning to integrated managed care? Has the ACH identified steps to address TA needs?

   ACH response:

7. What **non-financial** technical assistance has the ACH identified that HCA could provide to the ACH to help address provider readiness needs?

   ACH response:

8. How has the ACH engaged MCOs, the regional behavioral health organization, consumers, and other affected stakeholders in planning for the transition to integrated managed care?

   ACH response:

B. Milestone: Identified HUB lead entity and description of HUB lead entity qualifications (Project 2B only)

NOTE: This milestone pertains ONLY to Project 2B. If the ACH is not implementing this project, respond "Not applicable."

The ACH may insert or include as an attachment supporting graphics or documentation for the questions below, though this is not required.

1. Identify the Project 2B HUB lead entity, and describe the entity's qualifications. Include a description of the HUB lead entity's organizational structure and any relationship to the ACH. Describe any shared staffing and resources between the HUB lead entity and the ACH.

   ACH response: Not applicable.

2. Has the Project 2B HUB lead entity decided to move forward with HUB certification?
   a. If yes, describe when it was certified, or when it plans to certify.
   b. If no, describe how the HUB lead entity plans to maintain oversight of business, quality and clinical processes.

   ACH response: Not applicable.

3. Describe the Project 2B HUB lead entity's role and processes to manage the appropriate

HUB information technology requirements. Include a description of data governance (including clinical and administrative data collection, storage, and reporting) that identifies access to patient level data and health information exchange for HUB and care coordination staff, and referring or other entities.

ACH response: Not applicable.

C. Engagement/support of Independent External Evaluator (IEE) activities

1. **Attestation:** During the reporting period, the ACH supported Independent External Evaluator (IEE) activities to understand stakeholders' and partners' successes and challenges with Medicaid Transformation project implementation. ACH support or engagement may include, but is not limited to:

    - ACH participation in key informant interviews.
    - Identification of partnering provider candidates for key informant interviews.
    - Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects and related activities.

    Place an "X" in the appropriate box.

    Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

2. If the ACH checked "No" in item C.1, provide the ACH's rationale for not supporting IEE activities for evaluation of Medicaid Transformation. If the ACH checked "Yes," to item C.1 respond "Not applicable."

    ACH response: Not applicable. Please see attached list of provider organizations queried to complete survey (GCACH.SAR2.Attachment9.1.31.19).

Section 3: Standard reporting requirements (Project Incentives)

This section outlines requests for information included as **standard reporting requirements** for the semi-annual report. Requirements may be added to this section in future reporting periods, and the questions within each sub-section may change over time.

ACH-level reporting requirements

A. ACH organizational updates

1. **Attestations:** In accordance with the Medicaid Transformation's Special Terms and Conditions and ACH certification requirements, the ACH attests to complying with the

items listed below during the reporting period.

	Yes	No
a. The ACH has an organizational structure that reflects the capability to make decisions and be accountable for financial, clinical, community, data, and program management and strategy development domains.	X	
b. The ACH has an Executive Director.	X	
c. The ACH has a decision-making body that represents all counties in its region and includes one or more voting partners from the following categories: primary care providers, behavioral health providers, health plans, hospitals or health systems, local public health jurisdictions, tribes/Indian Health Service (IHS) facilities/ Urban Indian Health Programs (UIHPs) in the region, and multiple community partners and community-based organizations that provide social and support services reflective of the social determinants of health for a variety of populations in its region.	X	
d. At least 50 percent of the ACH's decision-making body consists of non-clinic, non-payer participants.	X	
e. Meetings of the ACH's decision-making body are open to the public.	X	

2. If unable to attest to one or more of the above items, explain how and when the ACH will come into compliance with the requirements. If the ACH checked "Yes," to all items respond "Not applicable."

   ACH response: Not applicable.

3. ***Attestation****:* The ACH has completed an organizational self-assessment of internal controls and risks using the attached template or a similar format that addresses internal controls, including financial audits.

   Note: the IA and HCA reserve the right to request documentation in support of attestation.

   Place an "X" in the appropriate box.

Yes	No
X	

   a. If the ACH checked "No" in item A.3, describe the ACH's process to address the self-assessment components contained within the checklist, including financial audits. If the ACH checked "Yes," to item A.3 respond "Not applicable."

   ACH response: Not applicable.

4. Key Staff Position Changes: Please identify if key staff position changes occurred during the reporting period. Key staff changes include new, eliminated, or replaced positions. Place an "X" in the appropriate box below.

	Yes	No
Changes to key staff positions during reporting period	X	

If the ACH checked "Yes" in item A.4 above:

Insert or include as an attachment a current organizational chart. Use ***bold italicized font*** to highlight changes, if any, to key staff positions during the reporting period (please see GCACH.SAR2.Attachment1.1.31.19).

B. Tribal engagement and collaboration

1. **Attestation:** The ACH attests to ongoing compliance with the Model ACH Tribal Collaboration and Communication Policy[4] (Please see GCACH.SAR2.Attachment2.1.31.19).

   Note: the IA and HCA reserve the right to request documentation in support of attestation.

   Place an "X" in the appropriate box.

Yes	No
X	

2. If the ACH checked "No" in item B.1, describe the rationale for the ACH not being in compliance with the Model ACH Tribal Collaboration and Communication Policy. If the ACH checked "Yes," to item B.1 respond "Not applicable."

   ACH response: Not applicable.

3. If tribal representation or collaboration approaches have changes during the reporting period, please explain. If there have been no changes, respond "Not applicable."

   ACH response: Not applicable.

[4] https://www.hca.wa.gov/assets/program/Model-ACH-Tribal-Collaboration-Communication-Policy.pdf

C. Integrated managed care status update (early- and mid-adopters only)

1. During the reporting period, what work has the ACH done to assist Medicaid behavioral health providers transitioning to integrated managed care?

   ACH response: HCA contracted with GCACH to provide support to the Greater Columbia BHO agencies. See table below.

Scope of Work	Deliverable	Date
Provide Project Management in the region to coordinate the work related to Integrated Managed Care (IMC)	• Coordinate workgroups • Facilitate stakeholder meetings • Liaise between the Contractor, Managed • Care Organizations (MCOs), physical • health providers, behavioral health • providers, the Behavioral Health- • Administrative Services Organization (BHASO) and county contacts. • Track and monitor contract work to ensure the IMC deliverables and timelines are being met.	7/2/2018-1/31/2019
Identify and establish members of a local Communications Workgroup to work with HCA to coordinate, develop, and disseminate a variety of IMC communications materials for Medicaid enrollees, providers, and other affected stakeholders.	• Submit a Communications Workgroup participant list. • Workgroup Members may include: A. IMC MCOs serving the region; B. Greater Columbia Behavioral Health (GCBH); C. HCA; D. A consumer representative or family member; E. Consumer advocacy organizations; F. Navigators, care coordinators, or community health workers; G. Area Agencies on Aging; H. A representative from major health systems in the regions; I. A representative from large Medicaid-serving behavioral health providers in the region; J. The behavioral health ombudsman.	7/16/2018
Identify and establish members of an Early Warning System (EWS) Workgroup to oversee the development and operation of the EWS in the region, as well as collaborate and coordinate with regional stakeholders to resolve issues that may arise	• Submit the EWS Workgroup participant list to HCA. • Workgroup Members should include: A. IMC MCOs in the RSA; B. GCBH; C. HCA; D. representatives from: i. major physical health providers, ii. behavioral health providers, iii. Contractor; and iv. criminal justice system, E. The behavioral health ombudsman.	7/16/2018

from the transition to IMC.		
Identify and establish members of a Provider Readiness Workgroup to assist in the provision of ongoing technical assistance (TA) and support to behavioral health providers in the region.	• Submit the Provider Readiness Workgroup participant list to HCA. • Members in the workgroup should include, but are not limited to: A. Current Behavioral Health Organization (BHO)-contracted behavioral health providers (Medicaid serving); B. Contractor; C. GCBH; D. IMC MCOs; and E. HCA.	7/16/2018 – June 2019
Provide a monthly report summarizing the activity of the project manager, and all IMC workgroups.	• The report must be submitted to HCA no later than the last working day of each month, beginning July 2018. • The report must include, but is not limited to: A. A summary of all work conducted that month, including: i. A detailed description of project ii. management and workgroup iii. activity(s); iv. ii. Copies of any PowerPoint, v. webinar, or meeting materials vi. used; vii. iii. Documentation of number of viii. participants; and ix. Contact information for any x. contracted consultants. B. Recommendations for HCA and providers to consider related to planning and project management, communications or provider readiness needs. C. A summary of activities planned the following month and status update related to: Early Warning System, Communications, and provider readiness.	Monthly – 12/31/2018
Provide a final report summarizing the activity provided during the contract period.	• The report must include, but is not limited to: A. A summary of the work conducted over the course of this Agreement, including: i. A detailed description of work conducted over the course of this agreement; ii. Copies of any PowerPoint, webinar, or meeting materials used; iii. Documentation of number of participants who received iv. technical assistance; and	1/31/2019

	v. Contact information for any contracted consultants. B. Identification of ongoing assistance needed; C. Lessons learned; and D. Any final recommendation to HCA to assist provider in other regions who are transitioning to IMC.	

During the reporting period, the ACH met with all 17 Behavioral Health agencies that are associated with the Greater Columbia Behavioral Health Organization (GCBHO). Throughout the meetings, each organization completed the Maine Health Access Foundation (MeHAF) and the Billing and Information Technology Self-Assessment Survey Tool. These two tools allowed GCACH staff and the behavioral health organizations to identify strengths and areas of opportunity that apply to Integrated Managed Care. Each organization completed a Practice Transformation Implementation Workplan (PTIW) that detailed action items that would help the organization successfully transition to Integrated Managed Care.

Throughout the reporting period, GCACH regularly facilitated three workgroups that were intended to prepare providers for Integrated Managed Care (IMC). These workgroups were: Provider Readiness, Early Warning System (EWS), and Integrated Managed Care Communications.

The Provider Readiness Workgroup was a good place to get information to the Providers. Many topics were discussed. At each meeting there were attendees from the behavioral health agencies, MCOs, GCBHO, and the HCA. The Provider Readiness meetings always began with a review of the Provider Readiness Workgroup Issue & Question Log. This log contained questions from all 17 behavioral health providers to be answered by the HCA and/or MCOs. The review of this log at every meeting facilitated learning and proactiveness among all the providers. Some of the topics were Non-Encounter Data Guidance, information on the new SERI Guide, instruction on how to register their NPI#s with HCA, readiness assessments for the MCOs, instructions for the Non-Emergency Medical Transportation that the providers can now use, Interpreter Services Team Presentation, and any other issues the providers may have. This workgroup was a great place for relationships to develop between the ACH, MCOs, HCA, and the BH Providers.

The IMC Communication Workgroup included the HCA, MCOs and some of the BH Providers to ensure a smooth transition to IMC through the development of clear communications materials and client notifications to help the clients understand the transition. The group met monthly and went over the written communications that were produced for the clients.

The Early Warning System Workgroup is a workgroup comprised of organizations that have direct knowledge of individuals that access systems of care that have the potential of getting lost in the transition to a managed care health system. This workgroup developed recommendations for an Early Warning System that allows a feedback loop and triage process to identify clients who may be falling through the cracks given the transition to integrated managed care and resolve system issues as they arise.

2. Describe how the ACH has prioritized, and will continue to prioritize, incentives to assist Medicaid behavioral health providers transitioning to integrated managed care. Include details on how Medicaid behavioral health providers and county government(s) have and will continue to participate in discussions on the prioritization of incentives.

ACH response:

GCACH will continue to support the BH Providers by continuing to have the Providers Readiness Workgroup meet biweekly and continue to support them as they transition to the IMC with any questions or any help they may need. The GCACH will continue to keep the communication lines open between the MCOs, HCA, and BH Providers.

GCACH will also help assist the BH Providers to get access to PreManage/EDIE with the sponsorship of the MCOs and helping them navigate the technology. GCACH will facilitate contracting with Direct Secure Messaging for the BH Providers.

Prior to the release of the second round of IMC funding, GCACH will meet with the Provider Readiness Workgroup to get their input on how these dollars should be allocated.

3. Describe the decision-making process the ACH used and will continue to use to determine the distribution of Behavioral Health Integration incentives. Include how the ACH verified and will continue to verify that providers receiving assistance or funding through the Behavioral Health Integration incentive funds will serve the Medicaid population going forward.

ACH response:

For the decision-making process GCACH allowed the BH Providers input as to how the initial $4 million of the incentive fund would be allocated. The Providers determined a base level of funding, $65,000 per organization, then used the formula that the BHO used to distribute the remaining funds. After the initial funding formula was developed, the GCACH Board of Directors approved the formula. The GCACH Board of Directors will be the decision-makers for the next round of funding with input from the Provider Readiness Group.

GCACH met with each BH Provider to discuss their needs and how their funds would be used. They completed the billing tool kit and GCACH helped assess the technical needs each organization needed. The BH Providers then submitted a budget of how the funds would be used as they are going through the IMC process. The proposed budget needed to be submitted

before GCACH paid the Providers their incentive funds. The Providers will have to submit a reconciled budget at the end of January 2019 to ensure the funds were used for the IMC Transition (please see GCACH.SAR2.Attachment4.1.31.19).

4. Apart from the distribution of incentives directly to behavioral health providers, how has the ACH supported Medicaid behavioral health providers to address business administration and/or operational issues ***after*** the transition to integrated managed care?

   ACH response:

   GCACH is continuing to support bi-weekly meetings with the HCA, MCOs, and BH agencies regarding claims, patient empanelment, and other issues (e.g. language services, transportation). By having the bi-weekly meetings it gives the BH Providers an opportunity to have the MCOs and HCA in one place to ask any questions they may have. GCACH is keeping a question log with all the questions from before the transition to current. GCACH sends it to the appropriate person either to the MCOs or HCA to address these questions. The GCACH will continue to keep the communication lines open between the MCOs, HCA, BH-ASO, and BH Providers.

   GCACH will help assist the BH Providers get access to PreManage/EDIE with the sponsorship of the MCOs. GCACH will facilitate contracting for Direct Secure Messaging for the BH Providers that want this tool.

   There will also be monthly webinars starting in February 2019 to address the Early Warning System indicators. GCACH will collect some encounter data and send it to HCA for these webinars. At the webinars, HCA will present information on the EWS indicators for the GCACH region, this allows a feedback loop and triage process to identify clients who may be falling through the cracks given the transition to integrated managed care and resolve system issues.

5. **Complete the items outlined in tab 3.C of the semi-annual report work--book.**

D. Project implementation status update

Implementation Plans are "living documents" that outline key work steps an ACH plans to conduct across the timeline of the Medicaid Transformation. The ACH's Implementation Plan (workplan) is a key resource that allows HCA to understand how the ACH is moving forward and tracking progress, and also provides information for HCA to monitor the ACH's activities and project implementation timelines.

As such, the ACH must submit an **updated implementation plan** that reflects *progress made during the reporting period* with each semi-annual report.[5]

- There is no required format, but the updated implementation plan must allow for the IA to thoroughly review progress made during the reporting period, as outlined in question 1 below.
- If the ACH has made substantial changes to the format of the workplan from that originally submitted as part of the implementation plan in October 2018, the IA may request an opportunity to discuss the format with the ACH to provide an orientation to the changes.

1. Provide the ACH's current implementation plan that documents the following information:
    a. Work steps and their status (in progress, completed, or not started).
    b. Identification of work steps that apply to required milestones for the reporting period.

    Required attachment: Current implementation plan that reflects progress made during reporting period (GCACH.SAR2.Attachment11.1.31.19).

2. At the portfolio level, provide the top three achievements and risks (including planned mitigation strategies and estimated timing for resolution) identified during the reporting period.

    ACH response:

    Top Three Achievements:

    - **Practice Transformation Toolkit, Workbook and Schedule:** Practice Transformation is the foundational strategy for the GCACH to bring about delivery system reform and achieve success across its four Medicaid Transformation (MTP) project areas. To facilitate this process, which is based on a standardized implementation of the Patient Centered Medical Home (PCMH), and guide participating providers in meeting milestone deliverables, the GCACH created a comprehensive Practice Transformation Implementation & Reporting Toolkit (Toolkit)(GCACH.SAR2.Attachment6.1.31.19), Practice Transformation Workbook (Workbook) (GCACH.SAR2.Attachment8.1.31.19) and Milestone Reporting Schedule (Schedule)(GCACH.SAR2.Attachment7.1.31.19). These documents were adapted from CMS' Comprehensive Primary Care (CPC) Implementation and Milestone Reporting Summary Guide, used nationwide, and ties into a portfolio approach the GCACH's four main project areas: bi-directional integration, transitional care,

[5] Note: ACHs are not to submit the narrative component of the October 2018 Implementation Plan.

opioid use management and chronic disease prevention. The Toolkit, Workbook and Schedule provide a broad but specific roadmap for GCACH's first cohort of Partnering Providers. The Toolkit is utilized by the Practice Transformation Navigators to assist the Partnering Providers to meet the milestones in the reporting schedule.

- **Early Successes with Practice Transformation:** One organization that has achieved early success is Lourdes Health Network in Benton and Franklin counties. Lourdes has now achieved bi-directional integration in their family medicine clinic and behavioral health counseling center. They have adopted a shared care plan, that is based on the Bree Collaborative guidelines and is now embedded into their EHR.

  Another organization achieving some initial gains has been Tri-Cities Community Health, also in Benton and Franklin counties. This FQHC has integrated bi-directional integration into their primary care practice using evidence-based approaches from the AIMS Center Collaborative Care approach. This is also being implemented and documented within the practice's EHR. TCCH is also involving medication management through embedded pharmacists within their practice sites.

  Practice Transformation is a comprehensive change management approach that involves considerable commitment of time and resources from the partnering organization. To support this work, the GCACH will be making significant financial investments into the participating provider organizations' practice models (e.g. IT infrastructure, milestone deliverables). Although there have been some questions around tactics, there has been overall buy-in and virtually no resistance to the PCMH process from the organizations. This leads us to believe that the transformation process will bring about lasting, sustainable change, post MTP.

- **KCHN Health Commons:** The Kittitas County Health Network (KCHN), based in Kittitas county, has worked collaboratively to improve the quality of life of Kittitas County community members at risk for needing a higher level of care. The KCHN is led by a group called the A-Team. The A-Team is comprised of healthcare, emergency response, mental health and community agencies who serve seniors and disabled people through collaboration and proactive planning. The target has been adults at risk of needing an increased level of care, which begins by identifying individuals vulnerable to "crisis" and then working holistically to provide patient centered care. This includes: social, environmental, medical, mental health, lifestyle, spiritual, and economic needs; all within the self-determination of the patient. To help deliver whole-person care services to high-need patients in their community, GCCH contracted with Quad Aim Partners (a technology consultant) to support KCHN to develop a Health Commons model. This model (HealthCommonsProject.org) works to digitally integrate community services by connecting KCHN agencies to a next generation IT system, called the Commons Network, which includes digital tools like Strata Health, The Collective Medical Platform, and cloud hosting services. Through application development, these services were integrated into an electronic referral management system that shares care plans and coordinates social

determinates of health. This system nearly finished its pilot project in the second of half of 2018 and will be going into production soon. GCACH anticipates that the Health Commons will act as the basis for the Opioid Resource Networks situated in Yakima, Tri-Cities, and Walla Walla.

Top Three Risks and Mitigating Strategies:

- **Contracting Delays:** Contracts with provider organizations undergoing Practice Transformation must be in place before base funding or funding tied to achieving milestone deliverables can be paid out. Therefore, delays in contracting pose a significant threat to the process. To mitigate this, the GCACH will create a learning collaborative in January involving all partnering provider organizations where they can review the contract with our Director of Finance and Contracts and ask clarifying questions. Additionally, the Director of Finance and Contracts provides technical assistance to organizations having difficulty understanding the milestones and contract language.
- **Participating Providers Failing the Practice Transformation Process:** The road to achieving PCMH status is difficult and involves significant work. As well, there have been a variety of implementations across provider organizations that haven't always shown full fidelity to the standard model. Rather than hiring an outside consultant to support this work, the GCACH has created a Practice Transformation department with a director and two Practice Transformation Navigators. These individuals will be directly responsible for this work and will be devoting considerable time in assisting each Practice Transformation organization with resources and technical assistance throughout the MTP. In addition, a formal learning collaborative curriculum has been outlined that will cover each of the PCMH core change concepts. These trainings will be occurring throughout the contract year and attendance is a requirement for achieving payment milestones. Practice Transformation Toolkit, Workbook and Schedule have also been created to support this work, as described above. There are also large financial incentives that will be paid out quarterly once the organization achieves milestone deliverables. Finally, organizations performing exceptionally well under the PCMH model will be paid to act as consultants to train, educate and mentor the remaining organizations within the current cohort.
- **Lagging Health IT Deployment:** Health information technology (HIT) is an essential part of implementing population health management (PHM) within a provider organization. EHRs are essential to any PHM strategy. However, EHRs were not originally designed to support PHM. Providers require patient registries, risk stratification tools, analytical reporting and more to identify care gaps, support care management and provide near real-time data required to intervene with patient sub-groups in a timely manner. To support provider requirements with HIT, the GCACH is providing Practice Transformation organizations with base funding ($140 thousand) in the first quarter of 2019 that will be used for purchasing population health management software. In addition, Practice Transformation organizations will be required to have in place direct secure messaging (DSM) capabilities

(e.g. DataMotion) that will support interoperability and communication between provider organizations and community-based organizations. The GCACH will also be facilitating the implementation of admission, discharge, transfer (ADT) notification software (PreManage) to support the monitoring of ED and inpatient discharges and care transitions. The GCACH Practice Transformation Navigators will be going through training on the GCACH-endorsed DSM vendor (DataMotion), and will provide technical assistance on utilization of PreManage. In addition, the Navigators will have the technical capabilities for turning on dormant EHR features to support the requirements outlined in Toolkit.

3. **Did the** ACH make adjustments to target populations and/or evidence-based approaches or promising practices and strategies during the reporting period?

   Place an "X" in the appropriate box.

Yes	No
	X

4. If the ACH checked "Yes" in item D.3, describe the adjustments made to target populations and/or evidence-based approaches or promising practices and strategies during the reporting period. Include the adjustment, associated project areas, rationale, and anticipated impact. If the ACH checked "No," to item D.3 respond "Not applicable."

ACH response: Not applicable.

Portfolio-level reporting requirements

E. Partnering provider engagement

1. List three examples of ACH decisions or strategies during the reporting period to avoid duplication across ACHs (e.g., assessments, reporting, training) and/or align with existing provider requirements as defined by MCOs and other health plans (e.g., reporting, quality initiatives, and practice transformation programs).

ACH Decisions/Strategies to Avoid Duplication and Promote Alignment		
Decision or Strategy Description	**Objective**	**Brief description of outcome**
Five ACHs (CPAA, OCH, N Sound, N Central, GCACH) have been coming together to share a contract with Oregon Health & Science University (OHSU). OHSU is an academic health	To discuss what constitutes good healthcare policy, in the context of the Medicaid Transformation Project, and how we can work together to advance such policies, to share funds	GCACH has gained insight into healthcare policies that advance health equity, better understood the project management

ACH Decisions/Strategies to Avoid Duplication and Promote Alignment		
Decision or Strategy Description	**Objective**	**Brief description of outcome**
center and is distinguished as a research university dedicated solely to advancing health sciences and developing health care policy that puts the patient first to improve access to high-quality health care for all.	flow and financial strategies, community engagement approaches, project planning and implementation successes and failures, and sustainability planning	approaches that other ACHs are taking, and contracted with CSI Solutions to develop a reporting platform that will be similar to N Central and OCH platforms
GCACH is participating in the Practice Transformation Consortium to share and align best practices	To reduce the burden on providers, and align interests in common trainings	A list of common trainings that the nine ACHS developed is being shared with the MCOs
The nine ACHs Leaders have been convening monthly with a healthcare consultant to advance a common agenda. These Peer Learning sessions are all-day, and we bring in partners and stakeholders to learn about their programs and services to find alignment. The ACH Leaders meet every Wednesday (ACH Huddle) to discuss HCA work products, issues that arise that are common to everyone, and to craft and align messages and requests to partners, HCA, and stakeholders.	To develop a common agenda on policy issues, MCO contracting, training needs, and to meet with HCA Leadership to discuss possible solutions	A common list of trainings has been developed, a contract is under development to work jointly with the MCOs, and reimbursement codes for care coordination and transitional care has been elevated to the HCA and legislative leadership. Additionally, the ACH leaders have been working on a Charter to guide their work of which 8 of the 9 ACHs have agreed to.

2. During the reporting period, how has the ACH engaged providers and community partners that are critical to success but had not yet agreed to participate in transformation activities (due to limited capacity, lack of awareness, etc.)? If the ACH has not engaged these providers during the reporting period, respond "Not applicable."

ACH response:

There are several opportunities for providers and community partners to participate in transformation activities outside of a formal contract with GCACH. GCACH is contracting with six Local Health Improvement Networks (LHINs) that act as "mini" ACHs across our nine-county region that convene on a regular basis to address local health priorities. Their contract deliverables include participation in the GCACH Leadership Council, a formal mechanism to get consumer input on health issues, alignment with programs of GCACH in their communities,

participation in training and education that will assist their members in accomplishing common goals, providing local performance metrics, sharing their membership roster with GCACH and more. The LHINs must attest to having financial stability and a fiscal agent to manage their funds.

Each LHIN attracts providers and partners from their respective communities that may or may not be involved directly with GCACH.

In the latter part of 2018, each LHIN finalized their work on determining their communities' priority social determinants of health, and will be allocated a portion of a $1.4 million Community Health Fund to address them. Each LHIN has had to select a third-party administration to select, score, and monitor projects that address their social determinants. Funding will be available to organizations with the best proposals.

The GCACH Leadership Council meetings attract an average of 50-60 people every month, with the vast majority of participants not under contract with GCACH for transformation activities. The meetings offer shared learning opportunities about practice transformation topics such as population health management, value-based purchasing, and progress on our four project areas, 2A, 2C, 3A, and 3D. GCACH used a Leadership Council meeting in October 2018 to invite community-based organizations to showcase their resources and programs available in the nine-county region. At this same meeting, reports from each LHIN were given that highlighted the issues and programs that their communities were working on (please see GCACH.SAR2.Attachment5.1.31.19).

GCACH convenes five committees that attract participation from non-contracted providers and community members: Budget and Funds Flow, Communications, Workforce, Data Management and Health Information Exchange (DMHIE), and the Practice Transformation Workgroup. Many people participating on these committees are not regular attendees of the Leadership Council meeting or contracted with GCACH for practice transformation, but many have subject matter expertise in workforce development, housing, emergency services, information technology, and philanthropy.

Finally, GCACH attends meetings in the community that relate to their project areas and meet stakeholders that are invited to attend GCACH events, and if interested, are put on the newsletter distribution list. GCACH has a newsletter that gets distributed to nearly 700 stakeholders every month.

3. Describe how the ACH supported active MCO participation to allow for MCO input and to send common signals to providers within the context of Medicaid Transformation, e.g., aligning performance expectations, VBP readiness support, billing and IT readiness support for IMC, etc.

ACH response:

Every committee of the GCACH invites participation from the broader GCACH membership,

and the MCOs have a seat on the Board of Directors and several committees. MCO representatives participate on the Budget and Funds Flow Committee, the DMHIE, Practice Transformation Workgroup, Communications Committee, and have been active members of the three integrated managed care committees, Provider Readiness Workgroup, Communications Committee, and the Early Warning System Committee. The MCOs were asked to participate on a panel at the November Leadership Council meeting on value-based purchasing, helped shape the criteria and selection of the first PCMH cohort, and have been welcomed to the ACH Peer Learning meetings.

At the August ACH Peer Learning meeting, MCO representatives and HCA leaders discussed the respective roles and accountabilities for ACHs, MCOs, HCA, and Providers in the implementation of VBP.

F. Community engagement and health equity

1. **Attestation:** The ACH has conducted communication, outreach and engagement activities to provide regular opportunities for community members to inform transformation activities during the reporting period.

   Note: the IA and HCA reserve the right to request documentation in support of attestation.

Yes	No
X	

2. If the ACH checked "No" in item F.1, provide the rationale for not conducting communication, outreach and engagement activities to support community member input. If the ACH checked "Yes," to item F.1 respond "Not applicable."

   ACH response: Not applicable.

3. Provide three examples of the ACH's community engagement[6] and health equity[7] activities that occurred during the reporting period that reflect the ACH's priorities for health equity and community engagement.

   ACH response:

   After establishing the Community Health Fund to address the social determinants of health (SDOH) in May 2018, communities throughout our 9-county region conducted close to 1,500 surveys to capture Medicaid consumer voices on what social factors are affecting their health.

[6] Community engagement is defined as outreach to and collaboration with organizations or individuals, including Medicaid beneficiaries, which are not formally participating in project activities and are not receiving direct DSRIP funding but are important to the success of the ACH's projects.
[7] Health equity is defined as reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.

The most common determinants are: housing, food insecurity, transportation, mental health, and education. The surveys were conducted in English and Spanish.

To ensure equity in awarding the projects to address these SDOH, GCACH is contracting with third-party administrators (TPA) (philanthropic organizations) to promote, solicit, score, select, and fund grantees. The Community Health Fund is worth $1.4 million and is being distributed through the TPAs. Additionally, applicant organizations are expected to solicit, incorporate, and implement feedback from Medicaid consumers during the course of the funded project.

GCACH engaged the Yakama Nation on multiple occasions to address the following:

- Explored ways to upgrade the technology of their social services and health programs.
- Facilitated several meetings between the Yakama Nation and the Astria/Toppenish Hospital to collaborate on behavioral health treatment of tribal members.
- Collaborated on efforts to bring the Nation their own designated crisis response unit.
- Supported the appeal to CMS to have a Designated Health Aide Therapist program for the Yakama Nation.

GCACH is working on a media campaign to bring awareness to the general public about the effects of adverse childhood experiences (ACEs), and the important role resiliency plays in overcoming them. In a recent conference in San Francisco, Dr. Felitti, one of the principle researchers of the ACEs study, touched on several health improvements experienced by the 17,000 study participants. The increased awareness they gained during the ACEs study lowered A1Cs, ED visits, and readmission rates.

The campaign will cover all nine counties and the Yakama Nation. It will be in multiple languages and run in several platforms such as radio, television, print, and social media. We will host high-profile speakers with expertise on ACEs and/or have inspiring lived experiences of resiliency to speak to crowds of mostly Medicaid consumers, professionals, and community members who are key to the success of the campaign.

The Communications Committee oversees the planning and execution of the campaign providing guidance to GCACH. In addition to the committee's guidance, GCACH formed a task force of subject matter experts to assist with the nuts and bolts of the campaign. Additionally, the plan includes focus groups to ensure the messages are targeted, sensitive and impactful. Medicaid consumer demographic and geographic representation is a must for the focus groups.

By going upstream to the root of our populations' poor health to address ACEs, and highlight the role resiliency plays in overcoming them, we are raising awareness that can lead to preventative health behaviors, much as it did with study participants. In addition, the campaign is likely to help us reach populations that are disconnected from healthcare delivery systems for a variety of reasons: transportation, immigration status, physical mobility, cultural, and behavioral health conditions.

Finally, although GCACH chose 4 projects, the ACEs/Resiliency campaign complements all of them, Reproductive and Maternal/Child Health in particular by raising awareness of the effects of child abuse and neglect and encouraging positive parenting. We believe that it can also help destigmatize seeking behavioral health treatment.

G. Budget and funds flow

Note: HCA will provide ACHs with a semi-annual report workbook that will reflect earned incentives and expenditures through the Financial Executor Portal as of December 31, 2018.

1. **Design Funds**

   Complete items outlined in tab 3.G.1 of the semi-annual report workbook.

2. **Earned Project Incentives**

   Complete items outlined in tab 3.G.2 of the semi-annual report workbook.

3. Describe how the ACH's Health Systems and Community Capacity investments intend to achieve short-term goals and/or broader transformation goals. Potential investments could include VBP training/technical assistance and/or the acquisition/use of certified EHRs by behavioral health, long-term care providers, and/or correctional health providers. Provide at least three examples, including how providers benefited from these investments.

   ACH response:

   GCACH is incenting providers to invest in population health management tools, and increasing the practice's capacity to deliver better health services by providing technical assistance in implementing the Patient-Centered Medical Home model of care. Health Information Technology offers powerful tools like disease registries, risk stratification, empanelment, automated reminders and alerts, and templates in the EHR that embed decision support into care. GCACH is training providers to use these tools that are essential to providing comprehensive primary care. These investments are meant to help providers in the short and long term, and to ready them for value-based payment contracts.

   GCACH has developed an Implementation and Reporting Toolkit (please see GCACH.SAR2.Attachment6.1.31.19), Implementation and Reporting Workbook (please see GCACH.SAR2.Attachment8.1.31.19), Milestone Reporting Schedule (please see GCACH.SAR2.Attachment7.1.31.19), and Revenue Sharing Model (please see GCACH.SAR2.Attachment3.1.31.19) that connect payment incentives to milestone deliverables (Please refer to these documents for a more detailed look at the incentives that are tied to each milestone).

   As soon as the contract between the Provider and GCACH is signed, it triggers a payment in the amount of $140,000 that is meant to be used for base population infrastructure. Milestone 8 requires that all eligible professionals within the PCMH practices successfully optimize their EHR, in line with the most up-to-date Office of the National Coordinator certification (ONC) standards.

Providers can earn up to $14,600 by participating in Practice Transformation Learning Collaboratives. The Learning Collaborative curriculum reinforces the milestones to ensure that providers are successful in implementing their change plans, and maximizing their incentive payments.

The reporting incentive earns providers the largest payment at $48,660, divided into four equal payments and dispersed quarterly based on achieved reporting deliverables. GCACH understands that providers feel that reporting is a burden, however, the intention of this reporting milestone (Milestone 5) is to help practices take a systematic, EHR-based approach to using data from and about their practices to drive quality improvement.

The movement toward integration of behavioral health and primary care is, in part, an attempt to bring the care to where the patients seek care, so this incentive payment for $14,598 offers an incentive to identify and meet the behavioral health care needs of each patient and situation, either directly or through co-management or coordinated referral.

4. If the ACH has elected to establish a community health fund or wellness fund, briefly describe the use or intended use of these funds to address social determinants of health and/or long-term health improvement strategies. Please describe how these strategies are linked to Medicaid Transformation goals.

ACH response:

Research points to the association between unaddressed social determinants and poor health outcomes. GCACH considers the social determinants of health as part of our overall healthcare delivery system, and attribute some of our high ED/jail/hospital readmission rates to poverty, education, homelessness, lack of transportation, food insecurity, and adverse childhood experiences. We established the Community Health Fund (CHF) so each community can access funding for projects that address the Social Determinants of Health and improve resiliency in ways that are meaningful to the community, build on existing programs, or have not yet been fully addressed through existing resources.

GCACH allocated $1,995,200 to the CHF to address Social Determinants of Health through the end of 2020. $1,395,200 will address the most basic needs in Maslow's Hierarchy of Needs such as housing and food insecurity, in addition to transportation, behavioral health, education, and employment.

The remaining $600,000 will be spent on an Adverse Childhood Experiences (ACEs) media campaign to bring public awareness to the link between ACEs and poor physical and behavioral health outcomes later in life. The campaign will also have a strong focus on the role resiliency plays in overcoming them.

Research also shows that 80% of a person's health is determined by social factors, of which, ACEs are part. With this two-prong approach, our intention is to go as far upstream as possible to improve population health, and reduce overall costs of healthcare through a reduction of

institutional care.

Section 4: Provider roster (Project Incentives)

A. Completion/maintenance of partnering provider roster

ACHs are to maintain a partnering provider roster as part of semi-annual reporting. The roster should reflect **all partnering providers** that are participating in project implementation efforts in partnership with the ACH (e.g., implementing Medicaid Transformation evidence-based approaches or promising practices and strategies).[8]

The provider roster will be a standard component of future semi-annual reporting, requiring ACHs to report any changes in partnering provider participation in transformation activities throughout the Medicaid Transformation. *Note: While the roster is a standard component, the requirements will evolve based on evaluation and assessment needs (e.g., provider participation at the clinic/site-level).*

ACHs are to include the list of providers in the Provider Roster tab of the semi-annual report workbook. ACHs are encouraged to use the initial provider list submitted in the first semi-annual report as a starting point and modify as needed.

1. In tab 4.A of the semi-annual report workbook, identify:
    a. All active partnering providers participating in project activities.
    b. Project participation by active partnering provider. Place an "X" in the appropriate project column(s).
    c. Start/end of partnering provider engagement in transformation activities by indicating the quarter and year.

    Complete item 4.A in the semi-annual report workbook.

2. Has the ACH established mechanisms to track partnering provider participation in transformation activities at the clinic/site-level? For example, does the ACH understand within each partnering provider organization which sites are participating? If not, please describe any barriers the ACH has identified related to tracking site-level participation, and how the ACH intends to overcome those barriers.

    ACH response:

    Greater Columbia ACH requested a selection of clinic sites from all partnering organizations. The clinic sites that were chosen by the partnering organizations were outlined in their

[8] Provider is defined as traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH's projects. Traditional Medicaid providers are traditionally reimbursed by Medicaid; non-traditional Medicaid providers are not traditionally reimbursed by Medicaid.

contracts with GCACH. Each site will be held accountable to achieving milestones which are also outlined in their contract. GCACH will track partnering provider participation in the practice transformation process through an on-line reporting platform (CSI). This tracking is at the practice site level.

Additionally, summary reports generated through the reporting platform will be reviewed by the Practice Transformation Workgroup on a quarterly cadence. The Contracts and Finance Director will track completion of deliverables and contract payments through the CSI platform and Excel spreadsheets. An individual spreadsheet has been created for each clinic site to track progress toward milestone completion. As milestones are completed, this triggers a sign-off by the Director of Practice Transformation to ensure the point value for each milestone is recorded.

Finally, attendance in the Learning Collaboratives will be monitored to ensure participation in transformation activities and to assist practices in implementing their change plans.

Section 5: Integrated managed care implementation (Integration Incentives)

A. Implementation of integrated managed care (mid-adopters only)

1. **Attestation:** The ACH region implemented integrated managed care as of January 1, 2019.

   Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

2. If the ACH checked "No" in item A.1, provide the ACH's rationale for not implementing integrated managed care in its region on January 1, 2019. If the ACH checked "Yes" in item A.1, respond "Not applicable."

   ACH response: Not applicable.

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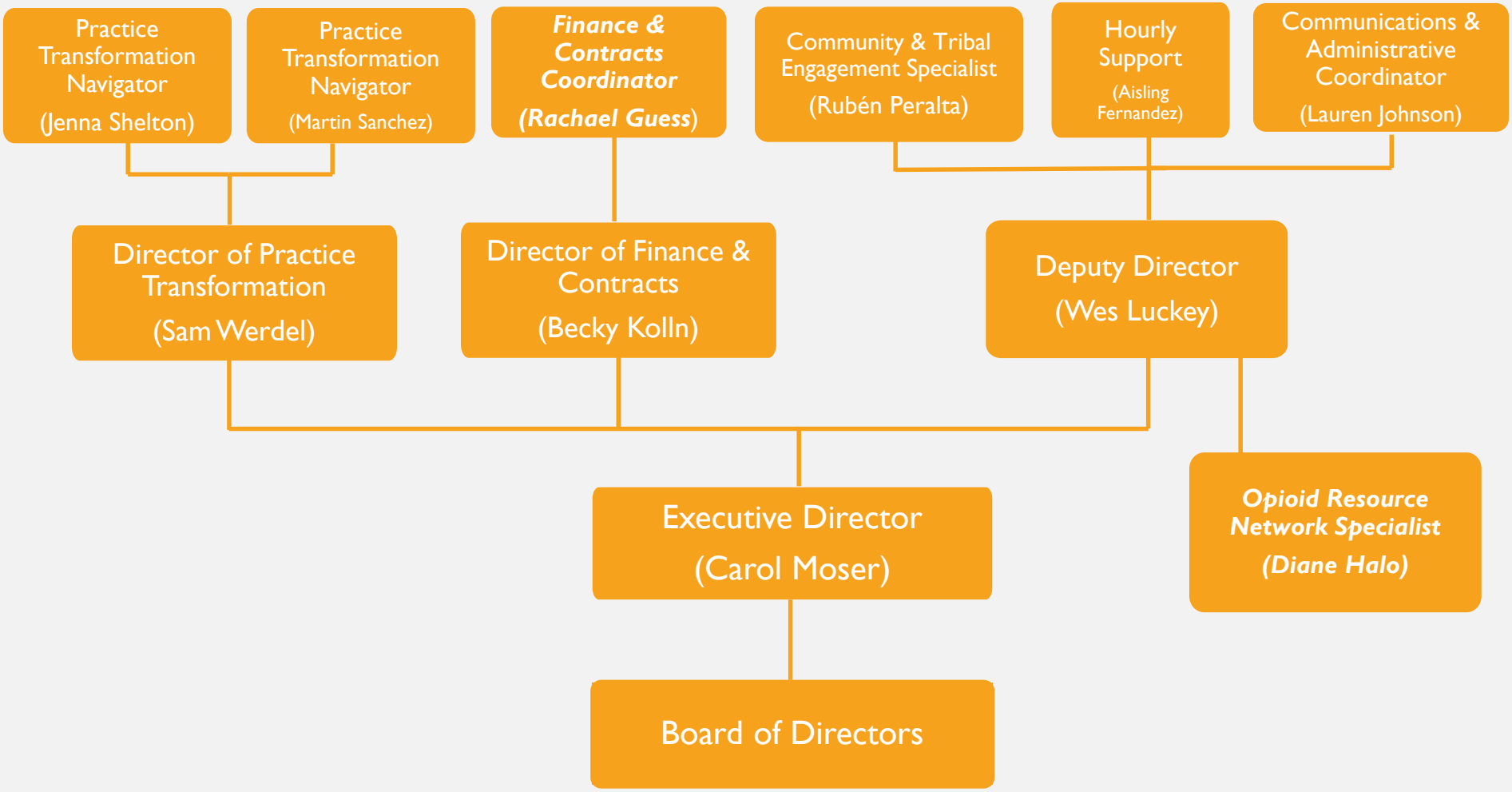
GREATER COLUMBIA
ACCOUNTABLE COMMUNITY OF HEALTH



Greater Columbia Accountable Community Health

Greater Columbia Accountable Community of Health (GCACH)

SUBJECT: Model GCACH Tribal Collaboration and Communication

Policy#: 2017-002

Version Date: May 18, 2017

Policy adopted by the GCACH Board of Directors by resolution on 5/18/2017
Yakama Nation confirmed policy approval on 6/22/2017

PURPOSE

To establish a clear and concise collaboration policy and communication procedure between the Greater Columbia Accountable Community of Health (GCACH) and Tribal governments, Indian Health Service (IHS) facilities, and Urban Indian Health Programs (UIHPs) in the development of all GCACH policies or actions.

GOVERNANCE

The GCACH will hold at least one seat on the GCACH governing board for the Tribes, IHS facilities, and UIHPs in its region to designate a representative.

[The GCACH and every Tribe, IHS facility, and UIHP may agree in writing to implement a modified version of Part II to support meaningful and feasible collaboration and engagement, including engagement with each sovereign Tribal government, IHS facility, and UIHP.]

COLLABORATION

The GCACH will collaborate and communicate with Tribal governments, IHS facilities, and UIHPs in a manner that respects the Tribes' status as sovereign nations and the IHS facilities' and UIHPs' status as congressionally established entities charged with meeting the federal trust responsibility and U.S. treaty obligations to American Indians/Alaska Natives.

- The GCACH will not refer to Tribes, IHS facilities, or UIHPs as stakeholders but as partners.
- The GCACH will collaborate with Tribes, IHS facilities, and UIHPs from the beginning of and throughout the planning and development process and engage in inclusive decision-making with Tribes, IHS facilities, and UIHPs for all GCACH actions that have an impact on AI/ANs, Tribes, IHS facilities, or UIHPs (as determined in accordance with Section IV) and not just solicit feedback from Tribes, IHS facilities, and UIHPs.

The GCACH will respect and support the need for:

  - Tribal representatives to inform their Tribal councils and receive directives from their Tribal councils on whether and how the Tribe would like to proceed with respect to any GCACH action.

- IHS facility representatives to inform their agency leadership and receive directives from their agency leadership on whether and how the IHS facility would like to proceed with respect to any GCACH action.

- UIHP representatives to inform their boards and receive directives from their boards on whether and how the UIHP would like to proceed with respect to any GCACH action.

If a Tribe, IHS facility, or UIHP declines an invitation to collaborate, the GCACH will maintain a standing invitation for the Tribe, IHS facility, or UIHP to collaborate with the GCACH.

DETERMINATION OF GCACH ACTIONS HAVING IMPACTS ON AMERICAN INDIANS/ALASKA NATIVES, TRIBES, IHS, OR UIHPS

The GCACH will establish a committee of GCACH and Tribal/IHS/UIHP designees. Such GCACH designees must include the GCACH lead staff member (e.g., GCACH executive director) and at least one GCACH governing board member who is not a representative of Tribes, IHS facilities, or UIHPs. The committee will meet regularly to determine whether any GCACH actions being contemplated, including the development of policies, programs, or agreements, will have an impact on American Indians/Alaska Natives, Tribes, IHS, or UIHPs. The GCACH lead staff person will ensure that sufficient information about GCACH actions is communicated during the meeting, and prior to implementation, to enable the committee to determine whether those actions will have an impact on American Indians/Alaska Natives, Tribes, IHS, or UIHPs. If no Tribe, IHS facility, or UIHP designates an individual to serve on this committee and until such time when a Tribe, IHS facility, or UIHP does designate an individual to serve on this committee, the governing board of the GCACH will make determinations of whether any GCACH actions being contemplated will have an impact on American Indians/Alaska Natives, Tribes, IHS, or UIHPs and inform the Tribes, IHS facilities, and UIHPs.

[The GCACH and every Tribe, IHS facility, and UIHP may agree in writing to implement a modified version of Part IV to support meaningful and feasible collaboration and engagement, including engagement with each sovereign Tribal government, IHS facility, and UIHP.]

COMMUNICATION

- The GCACH will work with each of the individual Tribes, IHS facilities and UIHPs to ensure that all contact information is up-to-date and the correct representatives are notified and regularly receive information.

- The GCACH will effect delivery of written information to Tribes, IHS facilities, and UIHPs concurrent with, and in the same format and method as, the delivery of written information to board members for board meetings, to committee members for committee meetings, and to other GCACH participants for participant or other meetings.

SOVEREIGNTY AND DISCLAIMER

The GCACH respects the sovereignty of each Tribe located in the State of Washington and that the Tribes and UIHPs have the right to request consultation with the State of Washington and/or the United States government in the event the GCACH fails to address the impacts on American Indians/Alaska Natives, Tribes or UIHPs. In executing this policy, no party waives any rights, privileges, or immunities, including treaty rights, sovereign immunities and jurisdiction. This policy does not diminish any rights or protections afforded AI/AN persons or Tribal governments or entities under state or federal law. The GCACH acknowledges the right of each Tribe and

UIHP to consult with state and federal agencies, including, where appropriate, the Health Care Authority, the Governor of the State of Washington, the Region X Administrator of the U.S. Department of Health and Human Services, or the President of the United States.

EFFECTIVE DATE

This policy will be effective on 5/18/17, and will be reviewed and evaluated annually at the request of any Tribe or UIHP or at the request of a majority of the GCACH governing board members.

APPROVED BY:

Rhonda Hauff

Councilwoman Leffie Sam

GRANT AND CONTRACT PROCESSING FORM

RECEIVED:

2018 OCT 29 AM 8:51

GRANTS AND CONTRACTS

Backup Documents Attached

_____	General Ledger Report	G/C Processing#	19.6045
_____	Forms (Budget/BM)	Department:	Human Services
_____	JE's	Program:	Behavioral Health
_____	Schedules	Award #:	
X	Other - Contract	Fund & Cost Center:	Accountable Communities of Health (ACH)
_____	Reviewed by In-House Counsel	Due Date:	10/31/2018
_____	Committee Action		

Purpose: ***Requesting Signature***

Need Councilwoman Lottie Sam signature for ongoing Greater Columbia Accountable Communities of Health for Tribal Collaboration and Communication agreement to continue services.

The above documents have been verified by:

_____ 10/22/2018
Program Manager Date

_____ 10/23/18
Deputy Director Date

The above documents have been verified by Grants & Contracts:

_____ 11.07.18
Grant/Contract Staff Date

_____ 11-7-18
Grant & Contract Manager

The above documents have been verified, signed and approved for processing by the Executive Committee

_____ 11/8/18
Executive Board Member Date

Original Document mailed to funding agency by: _____

Regular mail _____ **FAX** _____ **UPS** _____ **Federal Express** _____

_____ Signed copy sent to Program's Committee, Deputy Director and Grants &

Contracts on: _____ **by:** _____

ORIGINAL RETURNED
NOV 08 2018
From Tribal Council

EXHIBIT "A" TRANSFORMATION INCENTIVE ALLOCATION WEIGHTS AND VALUES "SAMPLE"

Greater Columbia Accountable Community of Health
Medicaid Transformation Project
Maximum Available Revenue Sharing for 2019

Hospital Partner: **Partner Size:** 1

Component	Points	Performance	Maximum Revenue Sharing	2019 Quarterly Maximum Revenue Sharing based on Milestones Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Bi-Directional Integration	3	100%	$14,598	$0	$7,299	$0	$7,299	$14,598
Assess	1	100%	$4,866	$4,866	$0	$0	$0	$4,866
Empanelment of Patients	0	100%	$0	$0	$0	$0	$0	$0
Risk Stratification	0	100%	$0	$0	$0	$0	$0	$0
Shared Decision-Making	1	100%	$4,866	$1,217	$1,217	$1,217	$1,217	$4,866
Health Information Technology	1	100%	$4,866	$3,041	$608	$608	$608	$4,866
Access and Continuity	0	100%	$0	$0	$0	$0	$0	$0
Patient & Family Engagement	2	100%	$9,732	$2,433	$2,433	$2,433	$2,433	$9,732
Hospital Care Management	7	100%	$34,063	$8,516	$8,516	$8,516	$8,516	$34,063
Chronic Care Management	3	100%	$14,598	$2,737	$4,562	$2,737	$4,562	$14,598
Reporting	10	100%	$48,661	$12,165	$12,165	$12,165	$12,165	$48,661
CA & Budget	1	100%	$4,866	$2,433	$0	$0	$2,433	$4,866
Practice Transformation Learning Collaboratives	3	100%	$14,598	$0	$0	$0	$14,598	$14,598
PTIW	1	100%	$4,866	$1,217	$1,217	$1,217	$1,217	$4,866
Training/Mentoring	2	100%	$9,732	$0	$0	$0	$9,732	$9,732
ED and Hospital Follow-Up	3	100%	$14,598	$3,650	$3,650	$3,650	$3,650	$14,598
Hospital Utilization	3	100%	$14,598	$3,650	$3,650	$3,650	$3,650	$14,598
Implementation of PM/EDIE	1	100%	$4,866	$3,041	$608	$608	$608	$4,866
Total 2019 Maximum Available Revenue Sharing	42		$204,375	$48,965	$45,924	$36,800	$72,687	$204,375

Component	Component Allocation	Maximum Revenue Sharing	2019 Quarterly Maximum Revenue Sharing based on Milestones Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Bi-Directional Integration	100%	$ 14,598.22	$ -	$ 7,299.11	$ -	$ 7,299.11	$ 14,598.22
Assess	100%	$ 4,866.07	$ 4,866.07	$ -	$ -	$ -	$ 4,866.07
Empanelment of Patients	0%	$ -	$ -	$ -	$ -	$ -	$ -
Risk Stratification	0%	$ -	$ -	$ -	$ -	$ -	$ -
Shared Decision-Making	50%	$ 2,433.04	$ 608.26	$ 608.26	$ 608.26	$ 608.26	$ 2,433.04
Shared Decision-Making	50%	$ 2,433.04	$ 608.26	$ 608.26	$ 608.26	$ 608.26	$ 2,433.04
Health Information Technology	50%	$ 2,433.04	$ 608.26	$ 608.26	$ 608.26	$ 608.26	$ 2,433.04
Health Information Technology	50%	$ 2,433.04	$ 2,433.04	$ -	$ -	$ -	$ 2,433.04
Access and Continuity	0%	$ -	$ -	$ -	$ -	$ -	$ -
Access and Continuity	0%	$ -	$ -	$ -	$ -	$ -	$ -
Access and Continuity	0%	$ -	$ -	$ -	$ -	$ -	$ -
Patient & Family Engagement	100%	$ 9,732.15	$ 2,433.04	$ 2,433.04	$ 2,433.04	$ 2,433.04	$ 9,732.15
Hospital Care Management	33%	$ 11,240.63	$ 2,810.16	$ 2,810.16	$ 2,810.16	$ 2,810.16	$ 11,240.63
Hospital Care Management	33%	$ 11,240.63	$ 2,810.16	$ 2,810.16	$ 2,810.16	$ 2,810.16	$ 11,240.63
Hospital Care Management	34%	$ 11,581.26	$ 2,895.31	$ 2,895.31	$ 2,895.31	$ 2,895.31	$ 11,581.26
Chronic Care Management	25%	$ 3,649.56	$ 912.39	$ 912.39	$ 912.39	$ 912.39	$ 3,649.56
Chronic Care Management	25%	$ 3,649.56	$ -	$ 1,824.78	$ -	$ 1,824.78	$ 3,649.56
Chronic Care Management	25%	$ 3,649.56	$ 912.39	$ 912.39	$ 912.39	$ 912.39	$ 3,649.56
Chronic Care Management	25%	$ 3,649.56	$ 912.39	$ 912.39	$ 912.39	$ 912.39	$ 3,649.56
Reporting	33%	$ 16,058.05	$ 4,014.51	$ 4,014.51	$ 4,014.51	$ 4,014.51	$ 16,058.04
Reporting	33%	$ 16,058.05	$ 4,014.51	$ 4,014.51	$ 4,014.51	$ 4,014.51	$ 16,058.04
Reporting	34%	$ 16,544.65	$ 4,136.16	$ 4,136.16	$ 4,136.16	$ 4,136.16	$ 16,544.65
CA & Budget	50%	$ 2,433.04	$ 2,433.04	$ -	$ -	$ -	$ 2,433.04
CA & Budget	50%	$ 2,433.04	$ -	$ -	$ -	$ 2,433.04	$ 2,433.04
Practice Transformation Learning Collaboratives	100%	$ 14,598.22	$ -	$ -	$ -	$ 14,598.22	$ 14,598.22
PTIW	100%	$ 4,866.07	$ 1,216.52	$ 1,216.52	$ 1,216.52	$ 1,216.52	$ 4,866.08
Training/Mentoring	100%	$ 9,732.15	$ -	$ -	$ -	$ 9,732.15	$ 9,732.15
ED and Hospital Follow-Up	100%	$ 14,598.22	$ 3,649.56	$ 3,649.56	$ 3,649.56	$ 3,649.56	$ 14,598.22
Hospital Utilization	100%	$ 14,598.22	$ 3,649.56	$ 3,649.56	$ 3,649.56	$ 3,649.56	$ 14,598.22
Implementation of PM/EDIE	50%	$ 2,433.04	$ 608.26	$ 608.26	$ 608.26	$ 608.26	$ 2,433.04
Implementation of PM/EDIE	50%	$ 2,433.04	$ 2,433.04	$ -	$ -	$ -	$ 2,433.04
Total 2019 Maximum Available Revenue Sharing		$ 204,375.11	$ 48,964.87	$ 45,923.58	$ 36,799.69	$ 72,686.98	$ 204,375.11

BHO-2018-01

Catholic Charities

Incentive Funding:	
Planned use of Funding:	**Planned Budget:**
New billing or electronic health record system	$ 50,000.00
Technical Assistance	$ 5,000.00
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	$ 5,000.00
Improvments to provider network	
Staffing	$ 120,000.00
Quality Improvement	$ 5,000.00
Support to implement integrated clinical models	$ 40,000.00
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	$ 5,000.00
Other:	
TOTAL:	**$ 230,000.00**

Incentive Funding:	
Actual use of Funding:	**Actual Cost**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	
Improvments to provider network	
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other:	
TOTAL:	$ -

BHO-2018-02

Ideal Balance

Incentive Funding:	
Planned use of Funding:	**Planned Budget:**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019	$ 114,520.00
Recruitment and retention of staff	
Improvments to provider network	
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other: 8 Computers	$ 12,752.00
TOTAL:	**$ 127,272.00**

Incentive Funding:	
Actual use of Funding:	**Actual Cost**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	
Improvments to provider network	
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other:	
TOTAL:	$ -

BHO-2018-03

Lutheran Community Services

Incentive Funding:	
Planned use of Funding:	**Planned Budget:**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019	$ 60,988.39
Recruitment and retention of staff	$ 35,000.00
Improvments to provider network	
Staffing	
Quality Improvement	$ 11,500.00
Support to implement integrated clinical models	$ 12,000.00
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other:	
TOTAL:	**$ 119,488.39**

Incentive Funding:	
Actual use of Funding:	**Actual Cost**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	
Improvments to provider network	
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other:	
TOTAL:	$ -

BHO-2018-04

Merit Resources (The Valley Alcohol Council)

Incentive Funding:	
Planned use of Funding:	**Planned Budget:**
New billing or electronic health record system	
Technical Assistance	$ 40,608.00
Operating expenses for 1st quarter 2019	$ 99,814.00
Recruitment and retention of staff	$ 1,000.00
Improvments to provider network	$ 2,000.00
Staffing	$ 50,450.00
Quality Improvement	$ 24,342.00
Support to implement integrated clinical models	$ 500.00
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	$ 4,000.00
Other:	
TOTAL:	**$ 222,714.00**

Incentive Funding:	
Actual use of Funding:	**Actual Cost**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	
Improvments to provider network	
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other:	
TOTAL:	$ -

BHO-2018-05

Serenity Point

Incentive Funding:	
Planned use of Funding:	**Planned Budget:**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019	$ 50,861.31
Recruitment and retention of staff	$ 14,500.00
Improvments to provider network	
Staffing	$ 5,000.00
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	$ 7,084.86
Other: Contract Negotation Consultant	$ 30,000.00
TOTAL:	**$ 107,446.17**

Incentive Funding:	
Actual use of Funding:	**Actual Cost**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	
Improvments to provider network	
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other:	
TOTAL:	$ -

BHD-2018-06

Somerset

Incentive Funding:	
Planned use of Funding:	**Planned Budget:**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019	$ 101,423.60
Recruitment and retention of staff	$ 3,200.00
Improvments to provider network	
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	$ 10,000.00
Other: Completing the Toolkit and MeHAF	$ 6,000.00
TOTAL:	**$ 120,623.60**

Incentive Funding:	
Actual use of Funding:	**Actual Cost**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	
Improvments to provider network	
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other:	
TOTAL:	$ -

BHO-2018-07

Sundown M Ranch

Incentive Funding:	
Planned use of Funding:	**Planned Budget:**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	
Improvments to provider network	
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other: Midway Analytics: Outcome and follow up studies 8/28/18 $37500 9/25/18 $33970.39 Remaining balance paid over 17 months at $3970.59 starting 10/10/18	$ 140,000.00
TOTAL:	**$ 140,000.00**

Incentive Funding:	
Actual use of Funding:	**Actual Cost**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	
Improvments to provider network	
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other:	
TOTAL:	$ -

BHO-2018-08

TRI-CITIES COMMUNITY HEALTH - - IMC BH Provider Incentive Funding

Incentive Funding:	
Planned use of Funding:	**Planned Budget:**
Technical Assistance	$ 28,000.00
Operating expenses for 1st quarter 2019	$ 62,841.83
Recruitment and retention of staff	$ 25,000.00
Improvements to provider network	$ 10,000.00
Support to implement integrated clinical models	$ 87,825.49
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	$ 30,000.00
Other:	
BHS Reception: Scanners (5)	$ 500.00
BHS Reception: Signature Pads (5)	$ 500.00
BHS Reception: Laptops for Case Managers to coduct home visits (5)	$ 5,000.00
BHS Reception: Computer Stands to support two monitors	$ 1,700.00
TOTAL:	**$ 251,367.32**

Incentive Funding:	
Actual use of Funding:	**Actual Cost**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	
Improvments to provider network	
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other:	
TOTAL:	$ -

BHO-2018-09

Yakima Valley Farm Workers Clinic

Incentive Funding:	
Planned use of Funding:	**Planned Budget:**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	
Improvments to provider network	
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other: Remodel and expansion of 12th Avenue space in Yakima to increase access to services.	$ 171,920.52
TOTAL:	**$ 171,920.52**

Incentive Funding:	
Actual use of Funding:	**Actual Cost**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	
Improvments to provider network	
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other:	
TOTAL:	$ -

BHO-2018-10

Barth Clinic

Incentive Funding:	
Planned use of Funding:	**Planned Budget:**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	
Improvments to provider network (Yakima Networking)	$ 2,264.56
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other: Payroll/taxes for remainder of 2018 (Sept-Dec)	$ 125,646.56
Other: ADA Door Installation	$ 7,000.00
Other: Heating/Air Unit	$ 9,000.00
Other: Microsoft Surface Go Tablet(12)	$ 5,283.93
Other: Computers (5)	$ 4,868.73
Other: Computer Refurb and upgrades	$ 2,163.73
Other: Topaz E Sign	$ 3,297.72
TOTAL:	**$ 159,525.23**

Incentive Funding:	
Actual use of Funding:	**Actual Cost**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	
Improvments to provider network	
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other:	
TOTAL:	$ -

Blue Mountain Counseling

Incentive Funding:			
Planned use of Funding:	**Planned Budget:**		Description use of funds
New billing or electronic health record system			
Technical Assistance	$	2,500.00	Use of consultant, if needed
Operating expenses for 1st quarter 2019	$	36,457.59	Self explanatory
Recruitment and retention of staff	$	4,500.00	Additional hours for Racheal
Improvments to provider network	$	1,500.00	Meeting time with allied providers
Staffing	$	18,000.00	Part-time person to help with billing/admin.
Quality Improvement	$	1,500.00	Additions/changes to current system (reports, etc)
Support to implement integrated clinical models			
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	$	3,000.00	Staff time to attend various meetings
Other:			
Tablets & Stands for surveys	$	2,500.00	To conduct surveys for consumers
Clearinghouse fees	$	2,500.00	Use of clearninghouse for billing/EFT/ERA
Changes needed in EHR for IMC	$	10,000.00	
TOTAL:	**$**	**82,457.59**	

Incentive Funding:	
Actual use of Funding:	**Actual Cost**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	
Improvments to provider network	
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other:	
TOTAL:	$ -

BHO-2018-11

BHD-2018-12

Comprehensive Healthcare

Incentive Funding:	
Planned use of Funding:	**Planned Budget:**
New billing or electronic health record system	$ 85,000.00
Technical Assistance	$ 25,000.00
Operating expenses for 1st quarter 2019	$ 721,500.00
Recruitment and retention of staff	
Improvments to provider network	
Staffing	$ 165,000.00
Quality Improvement	
Support to implement integrated clinical models	$ 125,000.00
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	$ 15,000.00
Other: Training	$ 20,000.00
TOTAL:	**$ 1,156,500.00**

Incentive Funding:	
Actual use of Funding:	**Actual Cost**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	
Improvments to provider network	
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other:	
TOTAL:	$ -

BHO-2018-13

First Step Community Counseling Services

Incentive Funding:	
Planned use of Funding:	**Planned Budget:**
New billing or electronic health record system	$ 21,252.00
Technical Assistance	
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	$ 170,000.00
Improvements to provider network	
Staffing	$ 12,000.00
Quality Improvement	$ 10,000.00
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	$ 10,000.00
Other: Furnishing IT products and other licensing requirements	$ 95,000.00
Other: Staff team building and strengthening tool kits	$ 4,000.00
TOTAL:	**$ 322,252.00**

Incentive Funding:	
Actual use of Funding:	**Actual Cost**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	
Improvements to provider network	
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other:	
TOTAL:	$ -

BHO-2018-14

Palouse River Counseling

Incentive Funding:	
Planned use of Funding:	**Planned Budget:**
New billing or electronic health record system	$136,978.27
Technical Assistance	$33,436.54
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	
Improvments to provider network	
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other:	
TOTAL:	**$ 170,414.81**

Incentive Funding:	
Actual use of Funding:	**Actual Cost**
New billing or electronic health record system	$136,978.27
Technical Assistance	$33,436.54
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	
Improvments to provider network	
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other:	
TOTAL:	$ 170,414.81

BHO-2018-15

Quality Behavioral Health
Integration Incentive Funding Budget- revised

Total Budget Amount $162,380.62

Incentive Funding:	
Planned use of Funding:	**Planned Budget:**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019: Operating reserves to ensure payment in initial months of integration as we figure out encounter billing to the MCOs.	$ 100,873.92
Recruitment and retention of staff	
Improvments to provider network	
Staffing	
Quality Improvement: Electronic signature pads for all clinical providers in order to capture client signatures in our EMR system. Cost: $364.99 per pad, with 35 clinicians= $12,774.65. Because the signature pads aren't supported by Cerner (our EMR) if they are attached to a thin client, some of the providers will need PCs purchased. Cost: $1,113.85 per PC and computer monitor, with 24 clinicians needing PCs = $26,732.40.	$ 39,507.05
Support to implement integrated clinical models: Specialized clinician training. Certification course in Nutritional and and Integrative Medicine for Mental Health Professionals. Course provides 17 CEU credits. Online course- total time of 17 hours. Cost: $199.99 per clinician, 35 clinicians to be trained= $6,999.65.	$ 6,999.65
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other: Consultation fees for continued contracting with MCOs through 2020 with the value based payment model	$ 15,000.00
TOTAL:	**$ 162,380.62**

Incentive Funding:	
Actual use of Funding:	**Actual Cost**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	
Improvments to provider network	
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other:	
TOTAL:	$ -

BHO-2018-16

Triumph Treatment Services (Yakima Valley Council on Alcoholism)

Incentive Funding:	
Planned use of Funding:	**Planned Budget:**
New billing or electronic health record system - set up and implementation	$ 72,000.00
Technical Assistance - E H R implementation support	$ 53,200.00
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	
Improvments to provider network	
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other:	
TOTAL:	**$ 125,200.00**

Incentive Funding:	
Actual use of Funding:	**Actual Cost**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	
Improvments to provider network	
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other:	
TOTAL:	$ -

BHO-2018-17

Lourdes

Incentive Funding:	
Planned use of Funding:	**Planned Budget:**
New billing or electronic health record system	$ 286,500.00
Technical Assistance	$ 3,500.00
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	
Improvments to provider network	
Staffing	$ 383,312.00
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other:	
Equpiment	$ 30,100.00
PC @ LCC	$ 90,000.00
rennovation @ LCC for PC	$ 125,000.00
TOTAL:	**$ 918,412.00**

Incentive Funding:	
Actual use of Funding:	**Actual Cost**
New billing or electronic health record system	
Technical Assistance	
Operating expenses for 1st quarter 2019	
Recruitment and retention of staff	
Improvments to provider network	
Staffing	
Quality Improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other:	
TOTAL:	$ -

Greater Columbia Accountable Community of Health

Collaboration · Innovation · Engagement

Meeting Minutes

October 18, 2018 | 9:00 a.m. – 12:00 p.m.

United Way of Benton & Franklin Counties | 401 N Young St, Kennewick, WA 99336

ATTENDANCE	
Participants (* denotes they called in, † denotes a GCACH Board Member):	Kirk Williamson, Jean Murrow, Chas Hornbaker, Sean Domagalski, Sierra Foster, Susan Campbell, Raul Morales, Michelle Sullivan, Martin Sanchez, Lisa Gonzalez, Heidi Berthoud, Rhonda Hauff†, Dr. Jocelyn Pedrosa, Marissa Ingalls, Sandy Quiroga, Hayley Middleton, Carla Prock, Morgan Linder, Dr. Kevin Martin, Leah Ward, Fenice Fregoso, Shannon Jones, Lupe Mares, Mark Lee, Annette Rodriguez, Bertha Lopez, Sandra Suarez†, Everett Maroon, AnaMaria Diaz Martinez, Leslie Stahlnecker, LoAnn Ayers, Sarah Giomi, Cass Bilot, Matthew Kuempel, Jac Davis, Michele Crowley, Corrie Blythe, Michelle Shearer, Yesica Arciga Garcia, Ben Shearer, Ron Jetter, Sue Jetter, Diane Campos, Scott Adams, Madelyn Carlson†, Marcy Durbin, Jorge Rivera, Stein Karspeck, Joyce Newsom, Annette Rodriguez, Tim Anderson, Jozelle Pheto, Liz Whitaker*, Meghan DeBolt*, Cicily Zornes*
Staff/Contractors (* denotes they called in):	Carol Moser, Wes Luckey, Becky Kolln, Rubén Peralta, Lauren Johnson, Sam Werdel, Diane Halo, Jenna Shelton, Martin Sánchez, Patrick Jones, Aisling Fernandez
Special Thanks:	• Thank you, United Way of Benton & Franklin Counties, for use of the facility. • Thank you to the CBO and LHIN leaders for presenting at the meeting.
MEETING PRESENTATIONS & REPORTS	
Community Based Organization (CBO) Fair (CBOs)	• The Community Based Organizations had tables around the room to showcase the work the organization is doing. Participants networked and shared information work being done in the region.

CBOs Description of Organization's Purpose and Services (CBOs)	• Rubén Peralta facilitated the meeting. He greeted all participants and had invited one representative from each guest Community Based Organizations briefly present on their work.
	  ○ Mark Lee: Communities in Schools
	  ▪ Communities in Schools is in 26 schools as of this year. This program has a paid staff member in the school all day who is present and part of the school, but he/she has flexibility that

	school staff does not have to help kids with their challenges. Chiawana High School in Pasco asked for a second person. Case manage 670 youth; 97% of those kids stayed in school. ○ Corrie Blythe: Southeast Washington Aging and Long-Term Care (SE WA ALTC) ▪ SE WA ALTC covers the GCACH region except for Whitman County and supports a comprehensive network of services by contracting and providing direct services in each community (e.g. advocacy for services, chronic disease care, durable medical equipment, counseling, fall prevention programs). ○ Joyce Newsom: People for People ▪ People for People (PFP) provides employment and training services, transportation for those with special needs. PFP is a key resource for emergency relief and will stay open 24-7 for emergencies. One of the two master contractors to help people apply efficiently for food stamps by phone, avoiding an office visit and paperwork. A key partner for ACEs education. ○ Carla Prock & Lisa Gonzalez: Benton-Franklin Health District (BFHD) (had two tables at the CBO Fair) ▪ A table to talk about Adverse Childhood Experiences (ACEs), which is a social determinant of health. BFHD provides a wide variety of community services including Women, Infant and Children, Environmental Health, and Communicable Diseases. The care coordination is primarily focused on childhood special needs and HIV care. ▪ A table to talk about Chronic Disease and Diabetes Self-Management Program (led by Lisa Gonzalez) which was initiated at BFHD in 2015. In 3 years, there have been 4 lay leader trainings and have trained 42 volunteers. Also do marketing through TV, radio and community outreach events. ○ Stein Karspeck: Richland Fire & Emergency Services ▪ A table to talk about how the emergency services work in Benton and Franklin Counties. The community includes fire districts (Benton City & West Richland). All the emergency services are accomplished by the Fire Departments. The future goal is to develop community paramedicine, which in addition to providing emergency response, also addresses the social determinants of health. You can help save a life. Talk to Stein and download it on your phone. ○ Annette Rodriguez: Yakima Neighborhood Health Services ▪ One of the services is meeting basic needs. The resource center called Neighborhood Connections screens and does assessments. They also provide a respite program for homeless individuals who are too sick to be in the streets but don't need to be hospitalized, and need a place to recuperate. An LGBTQ-friendly space where you can visit if you're 13 to 23 years old. ○ Jorge Rivera & Fenice Fregoso: Molina

	▪ It's been 4 years since GCACH had its very first meeting in Walla Walla. It has really grown into a massive community focus and has really been special. Molina helps with about 50% of people with Medicaid, was privileged to win first place for integrated managed care (IMC) and will move into IMC in 2019. Partnering is key, such as with housing agencies, case management, addiction recovery, health homes. Hiring more people for this area. Please don't see MCOs as payers only, but more as partners. o Tim Anderson: Merit Disability ▪ Merit Disability supports those who would qualify for Social Security disability, for those who are 64 or younger who haven't worked for 12 months because of physical conditions. This program has more robust benefits than others and helps them to get the resources they need. Partners with Molina. o Sara Giomi: Second Harvest ▪ Second Harvest is in 26 counties, work on hunger relief. Since 1971 working to fight hunger and feed hope! Empower, educate and change lives. Healthy food for every person every day. Food for kids in schools, mobile markets, and nutrition classes. o Bill Dixon: WSU Master Gardener Foundation of Benton/Franklin Counties ▪ Food from food gardens tend to be more nutritious. Robert Wood Johnson Foundation (RWJF) found that food gardening is a way to get more exercise and is good for mental health. Currently the food gardens program supports low-income gardeners and provides fresh produce to 1800 to 2400 people including the families of the gardeners. They continue to build new gardens and offer classes to people to teach ways to grow food in containers for those with no gardening space. o Yesica Arciga Garcia: Community Health Plan of Washington (CHPW) ▪ CHPW is a not-for-profit. Yesica told her personal story about how CHPW provided affordable dental care to her in the past and supports people like her in the community. o Everett Maroon: Blue Mountain Heart to Heart ▪ Blue Mountain Heart to Heart does case management for people living with HIV/AIDS. The Board and Everett having been working on services for opioid users. They are doing a syringe exchange in 4 counties in Oregon. Working on naloxone distribution. They opened in Pasco in May and have seen 75 reversals, in Walla Walla 88 reversals just this year. Statewide there have been 1600 naloxone reversals (AKA lives saved). There have been 187,000 syringes exchanged. o Raul Morales: Family Learning Center ▪ Raul serves on the Board and is an active volunteer. The Family Learning Center helps refugees coming into the Tri-Cities by helping with homework after school, taking families to the Oregon Zoo, taking them to Silverwood, getting to know this community, serving as a

	resource for them, becoming a connection between the schools and families, has citizenship courses, ESL for adults, a health ESL class. As a community, the Tri-Cities is one of the most welcoming for immigrants. The biggest need is mentorship of teens. 10 refugee kids involved with the Family Learning Center have graduated from high school and now attend CBC. ○ Matthew Kuempel: Lutheran Community Based Services ▪ Lutheran Community Based Services has offices all over Washington State. They work with the needs of the community, partner with ALTC. The local office has been meeting the needs of kids and youth with intensive mental health needs. The SWIFT program is for crisis stabilization for a MH or BH crisis at risk of harming oneself or someone else. The largest program is a wraparound service for those 21 or younger with intensive MH or BH needs, trying to get every system partner involved. One family, one plan: legal, school, MH, medical providers are all working together. Youth qualify not based on diagnosis but based on risk factors and environmental needs and the strengths factor assessment. ○ AnaMaria Diaz Martinez: WSU Extension Service ▪ WSU Extension Works through networking and collaboration. One of the programs is Strengthening Families, an evidence-based program, for prevention of drug and alcohol use in WA state. She partners with many of the organizations in the room that are working on family development. Always looking for community partners.
Welcome & Introduction (GCACH Staff)	• Rubén Peralta facilitated introductions by name and organization around the room and on the phone.
Local Health Improvement Network (LHIN) Reports (LHIN Leaders of WCHN, SW WA RHN, BMRCHP, BFCHA, YCHCC, & KVHN) († denotes a GCACH Board Member)	• Greater Columbia ACH has established six Local Health Improvement Networks (LHINs) across the GCACH region to provide a local voice and perspective to the Medicaid Demonstration Project. LHINs are comprised of local community leaders that provide direct and indirect services to advance the health of their population. • LHIN Leaders introduced themselves. ○ Scott Adams & Erin Sedam: Whitman County Health Network (WCHN) ▪ Scott Adams reported that WCHN has a Leadership Council. Through a County-wide needs assessment, they found that the three main needs are access to medical care, dental care and MH services. Great story about the benefits of this network working with YVFW to purchase a building in Pullman and collaborate for childhood dentistry services. Upcoming pilot in a school. Working on bi-directional integration. ○ Jac Davies & Martha Lanman: South East Washington Rural Health Network ▪ Jac Davies reported that SE WA RHN, which includes Garfield, Columbia and Asotin counties as well as 3 health systems, FQHCs, public health, BH, ALTC, transportation, 3 health departments, senior services, EMTs all attending monthly meetings (usually held) in Pomeroy. There are cross-LHIN activities as well. In 2018 worked on identifying projects and

aligning with GCACH work. The Community Health Fund Initiative captured the consumer voice with a survey in 3 counties and they are working on mapping these needs to the projects.

- Morgan Linder & Meghan DeBolt†: Blue Mountain Region Community Health Partnership (BMRCHP)
  - Morgan Linder reported that BMRCHP, of Walla County, currently has 92 people on the roster with a diversity of community organizations including business, hospitals, city and county government, and education. In the past year, they have been working with the community, working on perceptions of health needs and trying to bring data, specific indicators, and asset mapping to the process. Have just completed the CHNA and are distributing the results this week. Starting the CHIP next week. Looking at Social Determinants of Health.
- Kirk Williamson: Benton-Franklin Community Health Alliance (BFCHA)
  - Kirk Williamson reported that CHNA started in the 1990s as an effort to build a cancer center by bringing together a group of competing community leaders in a safe and collaborative space. Benton and Franklin counties has a large refugee community, much of which is not Hispanic, there's a great event about suicide prevention coming up, also EMS leaders are meeting to work on high 30-day hospital readmissions. Working with Senator Sharon Brown to create a community tip line.
- Rhonda Hauff† & Dan Ferguson†: Yakima County Health Care Coalition (YCHCC)
  - Rhonda Hauff reported that YCHCC has representation from many sectors and organizations. There is electronic access to the meetings to increase access. YCHEE was founded by community members and Rep. May Skinner in 2002 when they came together to talk about prioritizing the needs of Yakima valley. They have developed several position papers on topics including access to hospital care, Medicaid interpreting, prenatal care and support and public health. Focus on the uninsured and Medicaid populations. They have many partnerships and are working on integrated managed care. She talked about the PREPARE tool.
- Dr. Kevin Martin, Sue Grindle, John Raymond: Kittitas Valley Health Network
  - Kevin Martin reported that KVHN is located in a very rural area. The coalition formed to address a specific crisis and then once all of these talented people came together, they stayed together and kept meeting. They applied for a HRSA Rural Network Planning Grant. They completed a CHNA in 2012 and again this year. Ellensburg housing is too expensive and there's a shortage of daycare. The MH workgroup has been addressing suicide in the county. An ACEs group is getting off the ground. A Network Infrastructure group is working on sustainability and recruitment. Working on income inequality and food insecurity.

	• Rubén Peralta noted that GCACH and the LHINs are addressing the Social Determinants of Health and this topic is raised in every meeting. • For more information about the LHINs in the Greater Columbia region, visit: https://gcach.org/lhin
GCACH Report (GCACH Staff)	• GCACH staff members reported out on the highlights of their work in the last month: ▪ Jenna Shelton updated the Leadership Council on Practice Transformation work from the last month. The Practice Transformation Navigators have been working with Behavioral Health Providers participating in the Integrated Managed Care (IMC) transition. The PTNs have also completed 19 of the 23 kick-off meetings. ▪ Becky Kolln gave the WAFE Portal Update. GCACH is working with 17 BH providers to sign contracts for the design, development and implementation of fully integrated managed care. Twelve of the 17 BH providers have signed contracts. The next payment date is set for October 19th. ▪ Lauren Johnson informed the LC about the Tri-Cities Opioid Forum. The Tri-Cities Alliance for the Common Good will be gathering a panel of experts on addiction to share their knowledge and jumpstart a conversation about what people in our community can do to put an end to opioid abuse and start healing our families and neighborhoods.
Question & Answer (Rubén Peralta)	• In a brief Q&A session, a participant asked if we were to work toward general awareness in the community in any area, we would want to focus on resilience. The presenter replied that people will recognize what resilience they already have.
ADJOURNMENT	
Adjournment	• Meeting adjourned early at 11:42 a.m. • Minutes taken by Aisling Fernandez.
Thank you for your time and engagement with Greater Columbia Accountable Community of Health!	
The last 2018 Leadership Council meeting in 2018 will be from 9 a.m. to 11:30 a.m. on Thursday, November 15, 2018 at Columbia Basin College, Classroom L102 (2600 N 20th Ave, Pasco, WA 99301)	
No Leadership Council Meeting in December Monthly Meetings will resume in January 2019	

PRACTICE TRANSFORMATION IMPLEMENTATION & REPORTING TOOLKIT

GREATER COLUMBIA ACCOUNTABLE COMMUNITY OF HEALTH

Welcome Letter

Welcome to The Medicaid Transformation Project Program Year 2018/2019! This is your Program Year (PY) 2018-2019 guide to building capability within your practice to deliver the Medicaid Transformation initiatives, with the aim of improving the experience of care and health outcomes and reducing the overall cost of care for your patients. This Practice Transformation Implementation & Reporting Toolkit (Toolkit) outlines each milestone by intent, work, and reporting requirements you will need to do to achieve these milestones.

The Toolkit was created in response to Greater Columbia Accountable Community of Health's (GCACH) participation in Washington State's Medicaid Waiver with the Centers for Medicaid and Medicare Services (CMS). The Medicaid Transformation Project (MTP) is a five-year agreement with CMS that provides up to $1.5 billion of investments in local health systems to benefit Medicaid clients. This work is led by nine Accountable Communities of Health regions, each governed by a backbone organization responsible for convening local leaders from multiple sectors that impact health. GCACH has chosen the Patient-Centered Medical Home (PCMH) model of care to ready our practices for transformation, and to address four project areas: Bi- Directional Integration of Physical and Behavioral Health Care, Transitional Care, Addressing the Opioid Public Health Crisis, and Chronic Disease Prevention and Control.

The milestones are corridors of work that will help you build a practice capable of supporting the four GCACH projects areas. Additional corridors include: Access and Continuity, Risk-Stratified Care Management, Patient Caregiver Engagement and Coordination of Care Practices. These primary care functions supported by enhanced payment, better data, and optimal use of health information technology will improve care, achieve better health outcomes, and reduce the total cost of care.

We are excited to hear about your journey and growth in the coming year. We anticipate the first component of the GCACH Reporting Platform will be ready for your Milestone 1 in early 2019. PY 2018/2019 milestones reporting will be quarterly rather than annually. It is our hope that this quarterly schedule will help your practice team track its work and keep your leadership, faculty, GCACH, and payer stakeholders aware of your progress and plans. The quarterly reporting will also help gauge your practice's needs for support in the work throughout the year.

Review this Toolkit now and often. We hope that it will help you map the work in your practice to successfully achieve the milestones and integrate them into the care of your patients. This is an initial attempt to capture Milestone data. It is possible going forward that improvements to the reporting mechanisms could occur given Provider input.

GCACH Program Year 2018/2019

Practice Transformation Implementation & Reporting Toolkit

Patient-Centered Medical Home transformation is critical but challenging work. Many practices need support to successfully transform—support from practice coaches, learning collaboratives, consultants or peers. GCACH has hired the Director of Practice Transformation and Practice Transformation Navigators that provide hands-on support in the organizations through your journey.

PCMH Change Concepts for Practice Transformation are used to help assess and guide primary care practices through the PCMH transformation process. "Change concepts" are general ideas used to stimulate specific, actionable steps that lead to improvement. The Change Concepts were derived from reviews of medical literature and discussions with leaders in primary care and quality improvement. They are applicable to a wide range of primary care practice types and have been adopted by a number of regional and national initiatives nationwide. In addition to primary care practices, many of these concepts and their associated improvement workflows are applicable to a wide array of organizations that provide either hands-on or hand-off patient care.

Each Safety Net Medical Home Initiative (SNMHI) Change Concept includes "key changes." These provide a practice undertaking PCMH transformation with more specific ideas for improvement. Each practice must decide how to implement these key changes in light of their organizational structure and context. The SNMHI website provides access to implementation guides, assessment tools, presentations, and other materials on the Change Concepts, and payment and recognition resources. http://www.safetynetmedicalhome.org/

The Patient Centered Medical Home Assessment and the Maine Health Access Foundation Assessment are tools that can help practices and Practice Transformation Navigators rate a site's progress toward implementation of the 32 key changes. The key changes are not mandatory nor is achieving Patient-Centered Medical Home Assessment certification. However, it is encouraged for primary care settings.

These milestones will be linked to upcoming learning collaboratives sessions. Although this Toolkit is meant to guide your reporting, additional information will be provided through the learning collaboratives that will reinforce these concepts and milestones.

Greater Columbia provides resources to assist practices in providing the following components for transformation. Our framework includes eight change concepts in four "quarterly" milestone stages:

Laying the Foundation

- **Engaged Leadership**- Because leaders facilitate PCMH transformation by championing the culture of supporting and sustaining change. The key role for leadership is to identify and allocate resources specific to PCMH efforts. Leadership must also be physically present throughout transformation efforts to sustain staff energy and motivation.
- **Quality Improvement (QI) Strategy** - A QI strategy is an approach to change and provides a framework and tools for planning, organizing, monitoring, sustaining and scaling based upon data. A QI team is sponsored by leadership and focuses on the organization's strategic priorities. QI teams will adapt to change based upon data and also keep everyone on track with Parking Lot lists.
- **Empanelment**– The act of assigning individual patients to primary care providers (PCP) and care teams with sensitivity to patient and family preferences and a managed care organization assignment. Empanelment entails many workflows to support patient population management, workforce and acceptance of a finite number of patients, allowing each provider and care team to focus on specific needs of the patient.
- **Continuous and Team-Based Healing Relationships**- A small group of clinical and non-clinical staff along with the provider are responsible for the health and well-being of a panel of patients. Teams are variable based upon their specific roles, patient population and organization.
- **Access and Continuity**- Because health care needs and emergencies are not restricted to office operating hours, primary care practices optimize continuity and timely, 24/7 access to care guided by the medical record. Practices track continuity of care by provider or panel.
- **Care Coordination-** Planned Care for Chronic Conditions and Preventive Care: Participating primary care practices proactively assess their patients to determine their needs and provide appropriate and timely chronic and preventive care, including medication management and review. Providers develop a personalized plan of care for high-risk patients and use team-based approaches like the integration of behavioral health services into practices to meet patient needs efficiently. In addition to linking to community resources to facilitate referrals and social service needs.
- **Organized, Evidence-Based Care**- Patients with serious or multiple medical conditions need extra support to ensure they are getting the medical care and/or medications they need. Participating primary care practices empanel and risk stratify their whole practice population, and implement care management for these patients with high needs.
- **Patient-Centered Interactions-** Primary care practices engage patients and their families in decision making in all aspects of care, including internal improvements in the system of care.

Practices integrate culturally competent self-management support and the use of decision aids for preference-sensitive conditions into usual care.

GCACH guides development of these functions at each Medicaid Demonstration practice through a framework of "Quarterly Milestones." Each year, these milestones will be built upon and expanded based upon a roadmap that leads to successful reporting of GCACH Medicaid Project metrics, internal goals and ultimately Value-Based Payments (VBP). Participating practices will report their milestone progress regularly through the GCACH Reporting Platform. Greater Columbia supports practices in attaining the Medicaid Demonstration Milestones through state and regional learning networks, online and in-person collaboration opportunities, access to local and regional exemplar practices that provide mentoring and Practice Transformation Navigators who provide hands-on assistance. To support learning across payers, GCACH convenes managed care organization payers on both a regional and state basis to review and discuss data, trends, and strategies for improvement and alignment to state, GCACH and Centers for Medicare Services (CMS) metrics.

Key to Reporting Method

The "key to reporting method" references the type of reporting method that the provider will be required to enter through the GCACH Reporting Platform. The key to reporting method is listed for each milestone, in accordance with the following table.

Key to Reporting Method		
Key	Symbol	Definition
Selection (dropdown menu)	X	Section refers to a dropdown menu of options that providers can choose from in the Platform.
Data	#	Free-text entry of data (Numerator/Denominator) into the Platform.
Narrative (text box)	N	Brief description of reporting accomplishments. How are you achieving a particular milestone?

Milestones within the toolkit are separated into 6 sections: Intent, Implementation Framework, Key Questions, Resources, Reporting and Terms and Conditions. The Intent section communicates the overall intention of the milestone. The Implementation Framework section provides the reader with background information on the milestone. Within the Key Questions section, the reader will find a list of questions that will assist in the completion of the milestone. These questions are not meant to be answered via reporting, they are only intended to facilitate conversation within the Quality Improvement team. The Resources section provides links to helpful literature. The Reporting section details the deliverables for each milestone. Finally, the Terms and Conditions section mirrors the Milestone Reporting Schedule and provides a summary of the requirements for each milestone. Please note, each milestone may not contain all 6 sections.

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MILESTONE 1

Milestone	Milestone Category	Reporting Quarter	Reporting Method
1A.1	Budget - Proposed	Q1	X, #
1A.2	Budget - Reconciled	Q4	X, #

Milestone 1 Intent: Budget

Milestone 1 will help your practice set budget priorities for PY 2018/2019. Medicaid Transformation Project (MTP) practices can use the PCMH Budget Template provided by your Practice Transformation Navigator. The Practice Transformation Implementation Workplan (PTIW) processes effectively transform care by investing new revenue in priority areas for practice transformation by using budgeting tools and accounting processes to allocate funding that leads to the support of VBP. Implementation of these processes will support transformation of benchmarks and analytic capacity to maximize the likelihood of shared savings.

In PY 2018/2019, your practice will report a proposed budget by uploading the budget document into the GCACH Reporting Platform by February 15, 2019. Milestone 1 includes reporting the practice site's final funding and costs using the PCMH Budget Template for PY 2018/2019 by January 15, 2020 (see Appendix A- PCMH Budget Template).

Please bear in mind all information entered into the GCACH Reporting Platform may be subject to audit. Please keep all supporting documentation!

The material your practice provides is incredibly valuable, as it allows GCACH to understand your practice's strategies for delivery of high value, comprehensive primary care that can be disseminated to other innovative models and initiatives, as well as allowing your practice and GCACH to track progress. The revenue for the achievement of each milestones is paid out on a quarterly basis as a value/weight calculation; shown in the Transformation Incentive Allocation Weights and Values document.

Milestone 1 Implementation Framework: Budget

To set the budget for your practice successfully, it is important to consider the resource needs of PY 2018/2019 milestones. Using a structured process to plan your budget for PY 2018/2019 is an effective way to determine the financial investments needed to achieve the milestones. Please work with your Practice Transformation Navigators to assist you in completing your budget. Please reference the $140,000 base population infrastructure payment as well as the fullest achievement of each milestone based in the Transformation Incentive Allocation Weights and Values document.

Milestone 1 Reporting: Budget

1A.1 Budget - Proposed [Quarter 1] [X, #]

- **In PY 2018/2019, your practice will provide an estimated budget by February 15, 2019**.

1A.2 Budget - Reconciled [Quarter 4] [X, #]

- **By January 15, 2020, your practice will report final funding and costs for PY 2018/2019.**

This must be completed in the GCACH Reporting Platform. The GCACH Reporting Platform functionality will be available early part of 2019. If you are submitting the budget before the platform is available, you will be provided an alternative mechanism for reporting to the GCACH

Please note: If the difference between the proposed budget was greater than 10% from your reconciled budget, your practice will be asked to tell us why your proposed budget differed from the actual funds received.

Milestone 1 Terms and Conditions: Budget

A. Submit a proposed budget no later than February 15, 2019.

B. Submit a reconciled budget from PY 2019 by January 15, 2020.

MILESTONE 2

Milestone	Milestone Category	Reporting Quarter	Reporting Method
2A.1	Empanelment Status	Q1-4	#
2A.2	Risk Stratification Methodology	Q1-4	X, #, N
2A.3	Additional Opportunities for Those at Highest Risk	Q1-4	X, N
2B.1	Bi-Directional Integration of Behavioral Health	Q2, Q4	X, N
2B.2	Self-Management Support	Q1-4	N
2B.3	Medication Management	Q1-4	X, #, N

Milestone 2 Intent: Access and Continuity

The work in Milestone 2 addresses population health. The priority focus is on those at highest risk for poor outcomes and preventable harm. Your practice will need to routinely assess the needs for all of your patients through a risk stratification methodology that applies to every patient in the practice. You will need to build care management capacity into your care team to better address the needs of those patients you identified at highest risk.

In PY 2020/2021, your practice will continue this focus on the patients with the greatest need and potential for preventable harm by matching your risk stratification methodology to your care management resources. This may require refining your methodology or enhancing your care team resources, i.e., team-based care.

Milestone 2 is broken down into two categories: Access and Continuity and Care Coordination. These categories are shown on the Milestone Reporting Schedule (see Appendix C- Milestone Reporting Schedule). Within the Access and Continuity category the following topics are addressed: empanelment and risk stratification. Within the Care Coordination category, the following topics are addressed: bi-directional integration of behavioral health, self-management support, medication management, and care management.

Your practice will strive to provide continuity of care to PCP assignment by Quarter 4 of 2019. This means that the provider that the patient is empaneled to receives the majority of the visits from that patient. However, the initial focus is empanelment.

Milestone 2 Implementation Framework: Access and Continuity

Milestone 2 Category Part 1: Access and Continuity

Strategies are listed to provide additional opportunities to enhance your care team to care for those at highest risk and to better support those patients who may be in lower risk stratification, but are struggling to achieve their health goals and are at risk for poor health outcomes.

The care strategies — comprehensive medication management and routine and effective support for self-management support of three chronic conditions — add important tools to your practice over the course of the Medicaid Transformation Implementation.

Your practice will identify two of these primary care strategies indicated in Access and Continuity. You might choose to start with a strategy that you have already been testing in your practice or you might choose a new strategy to address an unmet need. Other strategies will be implemented as success is gained from primary strategies.

Practice-based risk stratification, empanelment and care management remain essential parts of Practice Transformation Implementation Workplan, and your practice will work toward maintaining at least 95% empanelment to provider(s) or care teams in PY 2019. Your practice risk stratification process should match available resources. To that extent, we suggest that your practice take another look its risk stratification strategy and, if necessary, refine it using applicable and available data sources and drawing on the experience of your exemplar partners in the Medicaid Transformation Implementation.
The target is to achieve risk stratification of at least 75% of empaneled patients and provide care management to at least 80% of patients you identified as those at highest risk. Those that are clinically unstable, in transition and/or otherwise need active, ongoing, intensive care management. Quarterly reporting will include updating information about your practice's risk stratification methodology, empanelment status, risk stratification data and care management staffing and activities.

The work in Milestone 2 addresses population health, targeting initially those at highest risk for poor outcomes and preventable harm. In PY 2019 you will begin to risk stratify your patients and provide intensive care management for those at highest risk. In PY 2020 you will continue this process and apply additional strategies to support patients struggling to achieve their health goals or at risk for poor health outcomes.

In the First Quarter of PY 2019, we will ask you to identify which primary care strategies your practice will pursue this year in fourth quarter PY2018/2019. Tell us the changes you are making in your practice as you implement these strategies. These questions highlight the requirements for effective implementation of each strategy. The intention of these questions is to help you plan and implement your approach and give us insight into how practices are implementing. This information will be recorded via your Practice Transformation Implementation Plan, (PTIW). The PTIW will also be housed as a live document in your Dropbox as well as a hard document in the GCACH Reporting Platform.

Milestone 2 Reporting: Access and Continuity

Empanelment & Risk Stratification

2A.1 Empanelment Status [Quarterly] [#]

1. Your practice will work toward maintaining at least 95% empanelment to providers or care teams in PY 2019. Provide the status of empanelment at your practice site. The denominator used to measure empanelment is the total number of active patients.

   Numerator: Total number of patients empaneled or identified in the EHR as being associated with a primary care practitioner in the practice

   Denominator: Total number of active patients

Enter the number of primary care practitioner or team panels at the practice site.

2A.2 Risk Stratification Methodology [Quarterly] [X, #, N]

1. Of the 95% of empaneled patients identified in 2A.1, the target is to achieve risk stratification of at least 75% of empaneled patients. Patients that are risk stratified will be grouped into risk categories from low to high risk. Provide care management to at least 80% of patients you identified as those at highest risk.

2A.2 Risk Stratification Types [Quarterly] [X, N]

1. Identify the data types that your practice uses to risk stratify. The risk stratification methodology your practice develops can use multiple types and sources of data (e.g., clinical, claims, utilization, etc.). The GCACH Reporting Platform will provide a list of possible types and sources for your practice to select, including the option of adding your own data source, if not listed.

   Please identify the data types that your practice uses to risk stratify. Select all that apply.

   - Claims (payers)
   - Clinical (practice, hospital, etc.)
   - Utilization
     - Number of ED visits
     - Number of office visits
     - Number of hospitalizations
     - Level of costs
   - Diagnosis
     - Diabetes
     - Congestive Heart Failure (CHF)
     - Asthma
     - COPD
     - Depression
     - Substance abuse
     - Cancer
   - Level of disease control
   - Number of medications
   - Score according to algorithm
     - Publicly available algorithm, please list known criteria
     - AAFP risk score
     - Proprietary, variables unknown
     - Other (narrative section will be provided)
   - Other psychosocial or behavioral risk factors, please list *(narrative section will be provided)*
   - Clinician judgment of risk
   - Other

2. Using the data types above, your practice will **provide a concise narrative describing the approach, methodology or tools used to stratify patients by risk and how this information is recorded in the EHR.**

   To show support for the selected approach, your practice may also upload up to three documents such as algorithms or policies and procedures that show your process. If your practice uploads documents, a list or summary of the documents must be added to a provided text box.

2A.2 Risk Stratification Statistics [Quarterly] [#]

1. Use the information in this section to record the total number of patients in each risk stratum and the number of patients within the stratum that received care management services during this quarter. Your practice may enter a "0" if there are no patients in a stratum or if your risk stratification methodology does not have that many strata. Your practice will complete a new table each quarter. This data will be used for internal and external benchmarking purposes.

   Numerator: The number of patients within stratum that received care management.

   Denominator: The total number of patients in stratum**.**

	Total number of patients in stratum:	**Number of patients within stratum that received care management:**
Highest stratum		
Second stratum of risk		
Third stratum of risk		
Fourth stratum of risk		
Low risk/no risk identified		
Not assigned a risk		

2A.3 Opportunities For Those at Highest Risk [Quarterly] [X,N]

1. Select two additional opportunities to enhance your care team to care for those at highest risk:

   - Planned Care for Chronic Conditions and Preventive Care
     - Use a personalized plan of care for each patient
     - Manage medications to maximize therapeutic benefit and patient safety at lowest cost
     - Proactively manage chronic and preventive care for empaneled patients
     - Use team-based care to meet patient needs effectively
   - Risk Stratified Care Management
     - Use care management pathways appropriate to the risk status of each patient
     - Manage care across transitions

    - Use evidence-based pathways for care
- Patient and Caregiver Engagement
    - Integrate culturally competent self-management support into usual care
    - Involve patient and family in decision making in all aspects of care

2. Select the care management activities that your practice uses for its patient population. Select all that apply:

    - Patient coaching
    - Education
    - Care plan development
    - Monitoring
    - Home visits
    - Hospital visits
    - Transition management (between both sites of care and providers of care)
    - Post-discharge contact
    - Other (text box will be provided)

3. Describe who on your staff provides care management services. All fields in the table are required. A text field will be provided for any additional information that you may want to share with GCACH. To save time, the number of practitioners from the previous quarter will be pre-filled in the table. Enter a zero if your practice does not have the specific provider type.

Care management services are provided by:	**Number of practitioners**	**Average patient caseload per practitioner this quarter**
APRN or Nurse Practitioner (NP)		
Medical Assistant (MA)		
Physician (MD/DO)		
Physician Assistant (PA)		
Registered Nurse (RN)		
Health Educator		
Other:		

Milestone 2 Implementation Framework: Bi-Directional Integration of Behavioral Health

Behavioral health care is an umbrella term for care that addresses mental health and substance abuse conditions, stress-linked physical symptoms, patient activation and health behaviors. Little of what we do in primary care is unrelated to behavioral health, but most practices have limited resources to support the well-trained clinician in providing this care. While most mental illness and substance abuse presents in primary care, most resources for management of these conditions have become siloed

outside of the primary care practice. The movement toward integration of behavioral health and primary care is, in part, an attempt to bring the care to where the patients seek care.

1. The practice is able to identify and meet the behavioral health (BH) care needs of each patient and situation,
   either directly or through co-management or coordinated referral.
    - The practice has an available range of skills in BH in the practice for primary care management of BH issues.
    - There is a training strategy (formal or on-the-job) to develop capacity for primary care management.
    - The practice has identified and collaborates with appropriate specialty referral resources in the health system (as applicable) and the medical neighborhood.

2. The practice has a systematic clinical approach that:
    - Identifies patients who need or may benefit from BH services
    - Engages patients and families in identifying their need for care and in the decisions about care (shared decision making)
    - Uses standardized instruments and tools to assess patients and measure treatment to target or goal
    - Uses evidence-based treatment counseling and treatment
    - Addresses the psychological, cultural and social aspects of the patient's health, along with his or her physical health, in the overall plan of care
    - Provides systematic assessment, follow up and adjustment of treatment as needed, reflected in the care plan

3. The practice measures the impact of integrated behavioral health services on patients, families and caregivers receiving these services and on target conditions or diseases and adapts and improves these services to improve care outcomes.

Milestone 2 Key Questions: Bi-Directional Integration of Behavioral Health

1. How do you use evidence-based tools and what team member is responsible? Practices integrating behavioral health use these tools for these functions:
    - Identifying the need for care
    - Engaging patients in decisions about care
    - Planning care
    - Monitoring progress and guide treatment to target or goal

2. What evidence-based treatments and counseling does your practice make available to patients in addition to medications when appropriate? Some examples include:

    - Problem-solving treatment
    - Cognitive behavioral therapy
    - Interpersonal therapy
    - Motivational interviewing.
    - Behavioral activation
    - 6 Building blocks

3. Engaging in a systematic case review and consultation for patients in active treatment for behavioral health issues supports treatment to goal or target. How do you identify and follow up with patients who drop out of active treatment? How and when does your practice review patients in active treatment and make specific recommendations for management if the patient is not improving? Who is part of the consultation and review team?

4. How are you building additional capacity for behavioral health in your practice, e.g., through training, hiring, contracting, co-management or referral arrangements or other strategies?

5. How many patients are you currently tracking/managing as receiving behavioral health services? Do you use a standalone registry for tracking patients or is this function integrated into your EHR?

6. What measures will you use to assess the integration of behavioral health and the impact of behavioral health services on your patient population? These might be measures of integration such as percentage of patients with a diagnosis of depression who are managed within the practice, key process measures such as percentage of patients with follow up within two weeks of initiating treatment, or measures of effective management, such as percentage of patients with depression who show improvement in scores on PHQ-9 over a period of time. These are examples only and the identification of useful and effective measures for your practice will be a topic of the learning collaboratives.

Milestone 2 Resources: Bi-Directional Integration of Behavioral Health

https://www.integration.samhsa.gov/events/2016/03/03/value-based-payment-readiness-a-self-assessment-tool-for-primary-care-providers-fqhcs-and-behavioral-health-providers

https://integrationacademy.ahrq.gov/products/ibhc-measures-atlas/what-integrated-behavioral-health-care-ibhc

https://www.pcpcc.org/content/benefits-integration-behavioral-health

https://aims.uw.edu/resource-library/cms-collaborative-care-payment-cheat-sheet

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

https://www.connectedmind.me/articles/2018/2/12/cpt-96127-billing-and-usage-guide

https://www.hca.wa.gov/assets/billers-and-providers/mental-health-svc-bi-20180101.pdf

Milestone 2 Reporting: Bi-Directional Integration of Behavioral Health

2B.1 Bi-Directional Integration of Behavioral Health [Quarter 2, Quarter 4] [X, N]

1. Choose one of the three models of Behavioral Health Integration:
    - Bree Collaborative
    - Co-location of Primary Care and Behavioral Health
    - AIMS-University of Washington Collaborative Care Model

2. Choose an evidence-based instrument or tool to systematically assess patients and monitor or adjust care.

    - Adult Attention-Deficit/Hyperactivity Disorder Self-Report Scale (ASRS-v11)
    - Audit-C
    - Brief Pain Inventory
    - Brief Psychiatric Rating Scale
    - Composite International Diagnostic Interview for depression
    - Drug Abuse Screen Test
    - Generalized Anxiety Disorder subscale (GAD-7)
    - Global Assessment of Functioning (GAF)
    - Mini Mental Status Examination
    - Montreal Cognitive Assessment
    - Mood Disorder Questionnaire
    - Patient Health Questionnaire for Depression (PHQ-2 / PHQ-9)
    - Primary Care Post-Traumatic Stress Disorder Screener (PC-PTSD)
    - PTSD Checklist (PCL-C)
    - Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)
    - Other (specify)

3. How have you organized the behavioral health services in your practice? For each of the services, identify who provides the services and how they fit into the system of care.

    Services Include:

    - Screening
    - Evaluation/diagnosis
    - Evidence-Based Treatment
    - Referral coordination
    - Tracking and measurement
    - Family and Caregiver Support
    - Peer support
    - Other (describe)

    After selecting each service, identify who providers this service:

    - Physician
    - PA

- APRN/NP
- Registered Nurse (RN)
- Licensed Practical Nurse (LPN)
- Medical Assistant
- Other Care manager
- Health educator
- Pharmacist
- Behavioral Health Specialist
- Behavioral Health Integration
- Practice care team
- Those available outside of the practice through contract or as a system resource (for practices that are within systems)
- Those available through coordinated referral in the medical neighborhood

4. Which assessment of behavioral health integration have you used to assess your practice?
    - AIMS Center Patient-Centered Integrated Behavioral Health Care Principles and Tasks
    - Integration Academy Self-Assessment Checklist
    - Maine Health Access Foundation
    - Patient-Centered Medical Home Assessment
    - Other (specify)

5. How are you identifying patients in need of integrated behavioral health services? Select all that apply:

    - Use of your risk stratification methodology
    - Positive screen (indicate screening tool used from Question 7 below)
    - The presence of a specific diagnosis (indicate diagnoses)
    - Inability to reach goals in management of chronic conditions (indicate target chronic conditions)
    - Other (specify)

6. Provide a concise narrative identifying how many patients are currently receiving integrated behavioral health services and being tracked in your EHR or standalone registry.

7. What evidence-based instruments or screening tools are you using to systematically assess patients and monitor or adjust care?

    Select all that apply:

    - Broad measure: Brief Psychiatric Rating Scale
    - Depression: Patient Health Questionnaire for Depression
    - Screening, Brief Intervention, Referral to Treatment (SBIRT)
    - Depression: PHQ-2, PHQ-9 mood disorders
    - Mood: Mood Disorder Questionnaire
    - Depression: Composite International Diagnostic Interview for depression
    - Anxiety: Generalized Anxiety Disorder subscale (GAD-7)
    - ADHD: Adult ADHD Self-Report Scale (ASRS-v11)

- Pain: Brief Pain Inventory
- OCD: Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)
- PTSD: PTSD Checklist (PCL-C)
- PTSD: Primary Care PTSD Screener (PC-PTSD)
- Alcohol use disorder: The Alcohol Use Disorders Identification Test (AUDIT-C)
- Drug Abuse Screen Test (DAST)
- Cognitive function: Montreal Cognitive Assessment
- Cognitive function: Mini Mental Status Examination
- Other (specify)

8. For each tool or instrument selected, identify when/how it is applied or used:

    - Identifying need for care
    - Follow-up and monitoring
    - Engage patients in decisions about care
    - Plan care
    - Other (describe)

9. Identify the team members responsible for applying or using that tool. Select all that apply:

    - Physician
    - Other Care manager
    - PA
    - Health educator
    - APRN/NP
    - Pharmacist
    - RN
    - Behavioral Health Specialist (specify what discipline)
    - LPN
    - MA
    - Other

10. What evidence-based treatments does your practice make available to patients in addition to medications when appropriate? Select all that apply:

    - Problem Solving Treatment
    - Behavioral Activation
    - Cognitive Behavioral Therapy
    - Interpersonal Therapy
    - Motivational Interviewing
    - Other (specify)

11. How and when does the practice do systematic case review and consultation (review of patients in active treatment with specific recommendations for management of patients is not improving) and outreach to patients who have dropped out of treatment?

    Systemic case review and consultation:

- Weekly
- Biweekly
- Monthly

12. Who is on the review team?

    - Psychologist
    - Psychiatrist
    - Social worker
    - Physician
    - PA
    - APRN/NP
    - Other

13. Identification and outreach to patients lost to follow up

    - RN
    - LPN
    - Other Care Manager
    - Other (specify)

14. Who does outreach?

    - Psychologist
    - RN
    - Psychiatrist
    - LPN
    - Social worker
    - Other Care Manager
    - Physician
    - MA
    - PA
    - APRN/NP
    - Other (specify)

15. What measures will you use to assess the integration of behavioral health and the impact of behavioral health services on your patient population? These might be measures of integration such as percentage of patients with a diagnosis of depression who are managed within the practice, key process measures such as percentage of patients with follow up within two weeks of initiating treatment, or measures of effective management, such as percentage of patients with depression who show improvement in scores on PHQ 9 over a specific period of time. (These are examples only and the identification of useful and effective measures for your practice will be a topic of the learning community.)

16. How have you increased your practice capacity to implement this program in the past quarter?

    - Training -MAT Training

- Hire or contract for new staff with behavioral health skills
- New referral or co-management arrangements
- None in this quarter
- Other (specify)

Milestone 2 Implementation Framework: Self-Management Support

Self-Management Support for at Least Three High-Risk Conditions

Many patients do not understand what their physicians have told them and do not participate in decisions about their care, which leaves them ill prepared to make daily decisions and take actions that lead to good management. Others are not yet even aware that taking an active role in managing their condition can significantly affect how they feel and what they are able to do. Enabling patients to make good choices and sustain healthy behaviors requires a collaborative relationship. A new health partnership between health care providers and teams, and patients and their families. The partnership should support patients in building the skills and confidence they need to lead active and fulfilling lives.

Milestone 2 Key Questions: Self-Management Support

1. What three high-risk conditions is your practice focusing on for self-management support and what triggers support for self-management? How many of your patients have the condition?
2. How do you help your patients gain the disease or condition-specific skills they need to manage the target disease or condition (beyond education in the context of the E/M [evaluation and management] visit with their physician, nurse practitioner, or physician assistant)? What is the training or credential required to provide this more intensive support (for example, the certification in diabetes education [CDE], or training in asthma self-management)? How many patients received training in managing their disease or condition?
3. What cross-condition strategies does your practice use to support self-management and who on the care team does this? Examples of these strategies include:
    - Between-visit planning and coaching, such as: 1) pre-visit development of a shared visit agenda with the patient; team preparation for the patient (e.g., through huddles or chart reviews); and coaching between visits with follow up of care plan and goals.
    - Goal setting and care plan or action plan development.
    - Discussion with the patient of their goals and documentation in the EHR.
    - Development of a care plan or action plan and documentation in the EHR.
    - Peer-led support and counseling; Peer-led support for self-management (for example, through chronic disease self-management programs), either in the practice or in the community.

4. What approach do you use to assist patients in assessing their need for self-management support? Some tools currently in use include:

    - How's My Health
    - Patient Activation Measure

5. Some evidence-based counseling approaches can effectively support self-management. Which approaches are you using in your practice and who has training in these approaches? Examples of these approaches include:

    - Motivational Interviewing
    - Reflective Listening
    - 5 As- 5 major steps for intervention
    - Teach Back

6. Practices can use a variety of tools to support self-management. These range from simple worksheets to help patients identify their agenda for a visit to web-based tools like the PeaceHealth Interactive Shared Care Plan. Which tools are you using and who on the care team uses this tool with patients?

7. Your community is likely to have valuable self-management support resources. What community resources do you routinely make available to your patients? How do you make the link, through information only or through formal referral or prescription? Does your relationship with these community resources include feedback on patient participation?

8. How are you building additional capacity for support of self-management in your practice through training, hiring, contracting, referral arrangements or other strategies?

9. What measures are you using to track the impact of support for self-management on care processes, health outcomes or costs for the three specific conditions of focus you have selected? You may already be focusing on these measures in your work in Milestone 5.

Milestone 2 Resources: Self-Management Support

https://www.ahrq.gov/professionals/prevention-chronic-care/improve/self-mgmt/index.html

http://www.improvingchroniccare.org/index.php?p=SelfManagement_Support&s=39

http://www.ihi.org/resources/Pages/Changes/SelfManagement.aspx

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

Milestone 2 Reporting: Self-Management Support

2B.2 Self-Management Support [Quarterly] [X, #, N]

1. Choose **one** of the four options for self-management support:

    - The practice team embeds self-management support tactics and tools into care of all patients and has intensive strategies available for patients at increased risk:

        - All members of the care team have basic communication skills to support patient self-management.
        - The practice routinely uses tools and techniques that reinforce patient self-management skills.
        - The practice routinely and systematically assesses the self-management skills and needs for patients with chronic conditions and this information is used to guide support for self-management.
        - The practice has a systematic approach to identifying patients with a need(s) for additional support in self-management.
        - The practice has a training strategy (formal or on-the-job) to develop staff/care team capacity to support self-management.

    - The practice uses tactics and tools that support self-management across conditions and supports patient acquisition of specific skills for management of target conditions or diseases.

        - Routine interval follow-up with patients about their goals and plans is a critical tactic for supporting patient self-management

    - The practice is able to measure how self-management support strategies affect target conditions or diseases and adapts and improves these strategies to improve care outcomes.

    - The practice develops and maintains formal and informal linkages to external resources to support self-management.

2. What high-risk conditions (at least three) are the focus for self-management support in your practice? How many patients in the practice have that condition? What triggers support for self-management?

    List conditions and number of eligible patients.

    List the triggers for each condition. Select all that apply:

    - All patients with the condition
    - General risk status (using the practice's risk stratification methodology)
    - Poorly controlled disease
    - Data from a formal self-management assessment tool
    - Patient expression of interest
    - Other (specify)

3. How do you provide your patients with disease or condition-specific skills for your target conditions (beyond patient education in the Evaluation and Management visits with a physician, nurse practitioner, or PA) and what are the training or credentials of the provider of disease or condition-specific skills? How many patients received training in managing their disease or condition this quarter?

Condition	Provided by (staff or external resource)	Training or credentials	Number of patients who received the intervention this quarter

4. What cross-condition strategies does the practice use to support self-management and who is responsible? Select the approaches and techniques. Select all that apply:

   Between-visit planning and coaching
   - Pre-visit development of a shared visit agenda with the patient
   - Team preparation for the patient
   - Coaching between visits and follow up on care plan and goals

   Goal setting and Care Plan/Action Plan development
   - Discuss patient goals and document in EHR
   - Develop care plan/action plan and document plan in the EHR

   Peer support and counseling:
   - Peer-led support for self-management
   - Group visits

   Team members for each approach and technique. Select all that apply:
   - Physician
   - PA
   - APRN/NP
   - RN
   - LPN
   - Other Care manager
   - MA
   - Health Educator
   - Behaviorist
   - Pharmacist
   - Community Health Worker
   - Community Resource
   - Other (specify)

5. What approach are you using to assist patients in assessing their need for support for self-management? Select all that apply:

    - Patient Activation Measure
    - How's My Health
    - In planning
    - Other (specify)

6. What evidence-based counseling approaches are you using in self-management support and who on the care team has the training for each selected approach? Select all that apply and narrative:

    - Motivational Interviewing
    - 5 As (5 Major steps for intervention)
    - Reflective Listening
    - Teach Back
    - Other (Specify)

    For each approach, who on the care team has the training? Select all that apply:

    - Physician
    - PA
    - APRN/NP
    - RN
    - LPN
    - Other Care manager
    - MA
    - Health Educator
    - Behaviorist
    - Pharmacist
    - Community Health Worker
    - Other (specify)

7. What specific self-management tools are you using and who on the team uses this tool? These can range from simple worksheets to help patients identify their agenda for a visit to web-based tools for the development of a shared care plan.

    List self-management tools you are using.

    For each tool listed, identify who on the team uses this tool:

    - Physician
    - PA
    - APRN/NP
    - RN
    - LPN
    - Other Care manager
    - MA
    - Health Educator

- Behaviorist
- Pharmacist
- Community Health Worker
- Other (specify)

8. What community-based resources do you make available to your patients for support for self-management and how do you link patients to this resource? Identify three to five community-based resources.

   List community-based resources you make available to your patients.

   For each community-based resource, indicate how the link between the patient and the resource is made. Select one per resource:

   - Information provided
   - Formal referral or prescription, without feedback
   - Formal referral or prescription with feedback report expected and tracked
   - Other (Specify)

9. How have you added to your practice capacity for support of self-management in the past quarter?

   - Training
   - Hire new staff with specific training or skills (e.g., Certified Diabetes Educator (CDE))
   - Contract for new staff with specific training or skills (MoU)
   - None in this quarter
   - Other (Specify)

10. What measures are you using to track the impact of support for self-management on care processes, health outcomes or costs for the conditions that you identified? Note that these can be the same measures tracked in Milestone 5.

Condition	**Measure(s)**

11. What new capacity have you developed in your practice this quarter in provision of support for self-management? Select the means of adding each capacity. Select all that apply:

    - Hiring
    - Training of existing staff
    - Contracting
    - Other
    - Formal relationship with external resource

Milestone 2 Implementation Framework: Medication Management and Review

We have not set targets or timelines for this work in PY 2018/2019 but do expect that your practice addresses each question every quarter and show progress in implementation on a quarterly basis. It should be the goal of your practice that the answers to the questions indicate that all key aspects of the work have moved out of the planning phase and into active testing and implementation by the end of PY 2019. The ultimate goal is to interface the Prescription Drug Monitoring Program (PDMP) into your organization's electronic health record system and systematically reference the PDMP at each visit and prescribing episode. (Not set targets or timelines due to the integration of PDMP in your EHR.)

Your practice can build a comprehensive system of medication management by integrating pharmacist(s) into the care team. The use of medications for primary and secondary prevention and for treatment of chronic conditions is a mainstay of medical practice. The potential for medication-related harm is increased in aged individuals with multiple comorbidities and those receiving care from multiple providers and settings. Many medications require scheduled monitoring for safe use. Protocol-guided medication management can improve outcomes in many chronic conditions. Medication reconciliation is a starting point for safer, more effective medication management, but great opportunities exist to more effectively and safely manage medication therapy across transitions of care.

Milestone 2 Key Questions: Medication Management and Review

1. What comprehensive medication management services does your practice provide beyond routine medication reconciliation? Examples include:

    - Coordination of medications across transitions of care settings and providers
    - Medication review and assessment aimed at providing the safest and most cost-effective medication regimen possible to meet the patient's health goals
    - Development of a medication action plan or contribution to a global care plan
    - Medication monitoring
    - Support for medication adherence and self-management
    - Collaborative drug therapy management
    - MAT trained clinician or referral source identified.

2. How does your practice engage pharmacist(s) as part of the care team? Do you engage pharmacist(s) as employees, through contract, through some other agreement, or are the pharmacist(s) provided to you as a system resource (for those practices in systems)? How much of pharmacists' time do you have per week?

3. How does the pharmacist(s) on your team engage in patient care? Some examples include:

    - Pre-appointment review and planning without patient present
    - Pre-appointment consultation and planning with patient
    - Coincident referral ("warm hand-off") for consultation
    - Follow-up referral or appointment request from the provider
    - Medication review and recommendations in the EHR (asynchronous with visit)

- Specified medication management appointment or clinic (e.g., warfarin management or lipid management)
- E-consultations with patients through patient portal or other asynchronous communication
- Home visit
- As part of a group visit.

4. How are patients selected for medication management services beyond routine medication reconciliation? Some example strategies include:

    - Patients in high-risk cohorts (indicate which cohorts)
    - Patients who have not achieved a therapeutic goal for a chronic condition (indicate the eligible conditions)
    - Patients with care transitions (indicate which transitions or any qualifying factors)
    - Patients with multiple ED visits or hospitalizations
    - High-risk medications
    - Complex medication regimens

5. Does your practice provide Collaborative Drug Therapy Management, and if so, for what conditions?

6. Does your practice target care transitions for comprehensive medication management services? If so, what triggers these services? Some examples include:

    - An ED visit
    - A hospital admission
    - A hospital discharge
    - A Nursing Facility or Skilled Nursing Facility admission
    - An NF or SNF discharge
    - A referral

    Do you provide this to all patients or those with specific risk factors?

7. What process measures will you use in your practice to improve medication effectiveness and safety?

Milestone 2 Resources: Medication Management and Review

https://www.ahrq.gov/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/interventions/medmanage.html

https://www.pcpcc.org/guide/patient-health-through-medication-management

Milestone 2 Reporting: Medication Management and Review

2B.3 Medication Management [Quarterly] [X, #, N]

1. Choose **one** of the following that indicates how your practice accomplishes medication management and review:

   - The practice has integrated a clinical pharmacist or pharmacists as a part of the care team. The integrated pharmacist's roles and responsibilities should include the following:

     - Works on site
     - Is involved in patient care, either directly or through chart review and recommendations, and documents care in the EHR
     - Participates in the identification of high-risk patients who would benefit from medication management
     - Participates in care team meetings
     - Participates in development of processes to improve medication effectiveness and safety
     - MAT trained clinician or referral source identified
     - Monitoring of the PDMP

   - The practice delivers comprehensive medication management services, which includes the following:

     - Medication reconciliation
     - Coordination of medications across transitions of care settings and providers
     - Medication review and assessment aimed at providing the safest and most cost-effective medication regimen possible to meet the patient's health goals
     - Development of a medication action plan or contribution to a global care plan
     - Medication monitoring
     - Support for medication adherence and self-management
     - Collaborative drug therapy management (when within the state's scope of practice)
     - Monitoring of the PDMP
     - MAT trained clinician or referral source identified

   - The practice has a systematic approach to the identification of patients to receive medication management services. Criteria could include some or all of the following:

     - Patients in high-risk cohorts already defined under Milestone 2
     - Patients who have not achieved a therapeutic goal for a chronic condition
     - Patients with care transitions
     - Patients are systematically referenced in the PDMP at each visit and prescribing episode
     - Patients with multiple ED visits or hospitalizations
     - Patients with high-risk medications or complex medication regimens

- The practice measures key processes and outcomes to improve medication effectiveness and safety

2. What comprehensive medication management services does your practice provide? This should include medication reconciliation and additional services. Select all that apply and narrative:

    - Medication reconciliation
    - Coordination of medications across transitions of care settings and providers
    - Medication review and assessment aimed at providing the safest and most cost-effective medication regimen possible to meet the patient's health goals
    - Development of a medication action plan or contribution to a global care plan
    - Medication monitoring
    - Support for medication adherence and self-management
    - Collaborative drug therapy management
    - PDMP Monitoring
    - Provider use of guidelines for prescribing opioids for pain (specify)
        - Bree
        - CDC
        - AMDG
        - Other (specify)
    - Key clinical decision support features for opioid prescribing guidelines (specify)
    - Linkage to behavioral health care and MAT for people with opioid use disorders (specify pathway)
    - Offer take home naloxone -Hospitals report ED site
    - Provides or refers to an access point in which persons can be referred to MAT
    - Refers or provides services aimed at reducing transmission of infectious diseases to persons who use injection drugs
    - Other (specify)

3. How does your practice engage pharmacists as part of the care team?

    - Direct Hire
    - System resource
    - Contract
    - In planning
    - Other agreement (specify)
    - Other (specify)

4. How many hours per week is the pharmacist engaged for coordination of care of medication management?

5. How does the pharmacist(s) on your team engage in patient care? Select all that apply:

    - Pre-appointment review and planning without patient present
    - Pre-appointment consultation and planning with patient
    - Coincident referral ("warm hand-off") for consultation
    - Follow-up referral from provider for appointment

- Medication review and recommendations in the EHR (asynchronous with visit)
- Specified medication management appointment or clinic (e.g., warfarin management or lipid management)
- E-consultations with patients through patient portal or other asynchronous communication
- Home visit
- As part of a group visit
- Other (specify)

6. How are patients selected for medication management services beyond routine medication reconciliation? These indications may be overlapping. Select all that apply:

    - Based on risk cohorts (indicate which cohorts)
    - Patients who have not achieved a therapeutic goal for a chronic condition (indicate the eligible conditions)
    - Patients with care transitions (indicate which transitions or any qualifying factors)
    - Patients with multiple ED visits or hospitalizations
    - High-risk medications
    - Complex medication regimens
    - Other (specify)

7. Does your practice provide Collaborative Drug Therapy Management?

    If yes, for what conditions?

    - Diabetes
    - Hypertension
    - Hyperlipidemia
    - Anticoagulation
    - Other

    If no, indicate the reason for not providing this service by selecting one of the following:

    - In planning
    - Intend to do this but have not started yet
    - Not supported by State Scope of Practice
    - This is not a change we feel will significantly impact outcomes or care for our patients
    - Other (indicate)

8. Does your practice target care transitions for comprehensive medication management services?

    If yes, what triggers these services? Check all that apply.

    - ED visit
    - Hospital admission
    - Hospital discharge
    - NF or SNF admission
    - NF or SNF discharge

- Referral

Who receives these services?

- All patients
- Patients with specific risk factors (specify)
- Other

If no, indicate the reason for not providing this service by selecting one of the following:

- In planning
- Intend to do this but have not started yet
- We address medication review, management, and coordination in this high-risk period in a different way (specify how)

9. What process measures does your practice use to improve medication effectiveness and safety?

Milestone 2: Terms and Conditions

A. 95% Empanelment in comparison to the appropriate care team or MCO assigned provider list.

B. Out of 75% of the empaneled patients; provide care management to at least 80% of patients you identified as those at highest risk.

C. Select additional opportunities from the Toolkit to enhance your care team to care for those at highest risk.

D. Select additional opportunities from the Toolkit to enhance your care team to care for those at highest risk.

E. Implement Bi-Directional Integration: Choose one evidence-based model of care and an evidence-based instrument or tool to systematically assess patients and monitor or adjust care.

F. All members of the care team have basic communication skills to support patient self-management. The practice routinely uses tools and techniques that reinforce patient self-management skills. The practice routinely and systematically assesses the self-management skills and needs for patients with chronic conditions. The practice routinely uses tools and techniques that reinforce patient self-management skills.

G. The practice is able to measure how self-management support strategies affect target conditions or diseases, and adapts and improves these strategies to improve care outcomes.

H. The practice uses tactics and tools that support self-management across conditions and supports patient acquisition of specific skills for management of target conditions or diseases: Conduct routine interval follow-up with patients about their goals and plans.

I. The practice develops and maintains formal and informal linkages to external resources to support self- management. The practice will develop infrastructure and planning via narrative reporting in quarters 1-2, and a systematic narrative for reporting in PY 2020, quarters 3-4.

J. The practice has a systematic approach to reconcile all patients' medications and identify high-risk patients that would benefit from medication management. Selection and narrative quarters 1-2 and data quarters 3-4.

MILESTONE 3

Milestone	Milestone Category	Reporting Quarter	Reporting Method
3A.1	24/7 Access by Patients & Enhanced Access	Q1-4	X, #, N

Milestone 3 Intent: 24/7 Access

Milestone 3 work increases access to primary care while supporting the relationships that lead to improved health outcomes. The focus of these changes is on increased access to care outside of the office visits.

Your practice will build access to the electronic health record so that data is available in the patient's medical record. In PY 2019, your practice will continue to ensure 24/7 EHR access while increasing your patients' access for care and consultation opportunities outside of office visits.

Milestone 3 Implementation Framework: 24/7 Access

In PY 2019, your practice will also expand patient access to your practice by providing for care and consultation outside of the office visit. This care can be synchronous (happening at the same time, as in telephone visits or instant messaging) or asynchronous (happening at different times, as in email consultation or communication through a patient portal). Obviously, asynchronous communication requires a practice commitment to timely responses, or it simply will not work for patients. This highlights the importance of including all care team members in the discussion around which approaches to care and consultation outside of the office visit are most feasible and achievable in your setting.

The planning for this Milestone links to Milestone 1 since this kind of care is not ordinarily compensated. You may want to think about how to make this a care team activity, rather than a provider-centric activity. Planning for this milestone may also stimulate practice discussion about productivity metrics and internal compensation strategies. Your Patient and Family Advisory Council (PFAC) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results might also be helpful as your practice considers different options for care and consultation outside of the office visit. You may want to work with your managed care organization (MCO) to strategize on opportunities for reimbursement for after-hours visits.

On a quarterly basis, your practice will attest to 24/7 access to the EHR to guide care, and if such access is not currently available you will need to provide a timeframe for implementation. Additionally, there will be quarterly identification of the approach or approaches your practice will take to provide care and consultation outside of the office visit and an estimation of the time your practice staff spends providing that care. This will help us understand the impact of expanding access in this manner. We will also ask you to tell us how you communicate the availability of non-visit care for your patients.

The work in Milestone 3 addresses access to care beyond the office visit. In PY 2018/2019, you ensured 24/7 access to care guided by the patient's information in the EHR. In PY 2020, you will improve

patients' access to care through providing opportunities for consulting with their provider or care team outside of office visits.

Your practice will attest to the completion of the PY 2019 requirements. **In PY 2019, all practices are asked to ensure that patients have 24/7 access to a care team practitioner who has real-time access to their EHR**. This could be provided by a care team member for your practice or through various coverage arrangements.

Milestone 3 Resources: 24/7 Access by Patients & Enhanced Access

http://www.aappublications.org/news/2017/06/21/Coding062117

http://www.physicianspractice.com/coding/how-code-negotiate-after-hours-reimbursement-your-practice

https://oig.hhs.gov/oei/reports/oei-07-11-00050.pdf

https://www.premierphysiciannet.com/Health-and-Wellness/Health-Topics/After-Hours-Clinics/

https://www.aapc.com/memberarea/forums/103639-online-visits.html

https://www.m-scribe.com/blog/telemedicine-billing-must-know-cpt-codes-and-gt-modifiers

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm5972.pdf

http://www.physicianspractice.com/coding/coding-patient-thats-not-present

https://medicalhomeinfo.aap.org/tools-resources/Documents/AAP%20care%20coordination%20coding%20fact%20sheet.pdf

Milestone 3 Reporting: 24/7 Access by Patients & Enhanced Access

3A.1 24/7 Access by Patients & Enhanced Access [Quarterly] [X, #, N]

1. Please confirm that your practice's patients continue to have 24 hour/7 day a week access to a care team practitioner who has real-time access to their EHR.

    - Yes
    - No

If no, when does your practice expect to have 24/7 access to your EHR for all practitioners covering calls after patient hours?

- Within 3 months
- Between 3 and 6 months
- More than 6 months

2. Please tell us how your practice is providing enhanced patient access. (Care provided to patients outside of office visits in a timely manner) Select all that apply:

    - Patient portal messages
    - Email
    - Text messaging
    - Structured phone visits
    - In progress/we are currently building this capacity
    - Other (specify)

3. To enhance reimbursements from the MCOs it benefits the practice to track hours of care provided outside of the office. **On average, about how many hours per week does staff spend on care provided to the patient outside of office visits?** Please complete the following table. Enter "0" if your practice does not have the specific staff category. Estimate the total hours per week for each quarter. Use whole numbers only with no decimals.

Staff Time Spent on Care Provided Outside of Visits					
Category	**Number of Staff in Category**	**Estimated Hours per Week in Quarter 1**	**Estimated Hours per Week in Quarter 2**	**Estimated Hours per Week in Quarter 3**	**Estimated Hours per Week in Quarter 4**
Physician					
PA					
APRN/NP					
RN					
LPN					
MA					
Health Educator					
Behavioral Health Professional					
Administrative					
Pharmacist					
Other (specify)					
Other (specify)					

4. Enhanced access or care provided outside of normal office hours is a new concept for patients and their families. This new concept needs to be communicated to patients. **How does your practice indicate information about enhanced access to patients and families?**

    Select all that apply:

    - Poster in office
    - Hand-out given to patient in office
    - Website

- Mailing to patients
- Verbally from staff
- Other (Specify)

Milestone 3 Terms and Conditions: 24/7 Access by Patients & Enhanced Access

A. Attest that the patients continue to have 24/7 access to a care team practitioner who has real-time access to the EHR.

B. Enhance access by implementing at least one type of opportunity for care provided outside of office visits.

C. Staff time spent on care provided outside of visits.

D. Commitment to timely responses.

MILESTONE 4

Milestone	Milestone Category	Reporting Quarter	Reporting Method
4A.1	Patient Experience - Patient-Centered Interactions	Q1-4	X, #, N
4A.2	Patient Experience - Shared Decision Making	Q1-4	#, N

Milestone 4 Intent: Patient Centered Interactions

The work in Milestone 4 is to support patients as engaged, informed, and effective partners in their own healthcare. In PY 2019, your practice will explore decision aids to support shared decision making. The work in this milestone aligns with your efforts around support for self-management and patient and family engagement.

Milestone 4 Implementation Framework: Patient Centered Interactions

The work in Milestone 4 puts the patient and family at the center of care. Your practice will use the PFAC and brief, in-office surveys to understand the patient perspective and engage patients and families as partners in improving care. Practices will continue in PY 2019 the work of engaging patients and family as valuable partners, through either office-based surveys or a PFAC. For practices that have both office-based surveys and PFAC, the goal of these activities is to use the voice of the patient to guide your efforts to improve care for your patients.

Additionally, the work in Milestone 4 is to support patients to be engaged, informed and effective partners in their own health care. Through the work in Milestone 4 you will be exploring the use of decision aids to support shared decision making between providers and patients in preference-sensitive care. In PY 2019, you will test a decision aid as a way to engage patient in shared decision making. In PY 2020, you will add additional aids and achieve increased use of these aids as you engage patients and families in making important decisions about their health.

The team can consider including recommendations from PFAC as they determine the best decision aids for your practice and, more specifically, for your patient population. It may be helpful to use the eligibility criteria provided in each decision aid. In addition to clarifying eligibility criteria for the decision aids, your practice will want to determine who, how and when you will identify the eligible patients for the decision aid. Advanced preparation of the decision aids can streamline the process and allow for better tracking of the distribution.

Documenting the use of decision aids will not only facilitate patient follow up, but also enable your practice to track usage of the aids. If your practice mails the decision aids or sends them home for viewing, you will need to have a plan for their return and ensure that the patient has an opportunity to discuss questions and preferences with the provider.

In PY 2018/2019 your practice can choose to track use of the decision aids as a rate (the number of individuals who are given the aid divided by the number who should have been given the aid) or as a

simple count of the number of patients provided with the decision aid. This change reflects the difficulty many practices may have in reporting on this milestone in previous years, ideally a template should be built in the EHR system and allow for automated reporting.

These are the three key components of the work in Milestone 4:

- A condition where legitimate treatment options exist and the scientific evidence can clarify the options but doesn't present a clear best choice
- A decision aid that helps the patient understand the evidence and think through the choices
- The opportunity to engage with the provider in making the decision (shared decision making)

Milestone 4 Key Questions: Patient Centered Interactions

1. What is a Monthly Practice-based Survey?

   Office-based surveys generally use convenience samples and are most valuable when you have multiple data points. The patterns that emerge from the data points will give you a sense of how your practice's changes are affecting your patients' experience of care. Monthly data gives you a much better sense of these patterns and trends. The data will help guide your practice as you test changes on a more rapid cycle.

2. What is a Patient and Family Advisory Committee (PFAC)?

   Patient and Family Advisory Committees offer your practice regular and frequent opportunities to collaborate with patients and families for guidance as you test changes in your practice. A highly active PFAC will provide invaluable guidance for your work in all of GCACH Milestones. Members of the PFAC typically include highly engaged patients, family members, caregivers, and staff.

3. What is Shared Decision Making?

   Shared decision making is an approach to care that seeks to fully inform patients about the risks and benefits of available treatments and engage them as participants in decisions about the treatments.

4. What is Preference-Sensitive Care?

   Preference-sensitive care comprises treatments for conditions where legitimate treatment options exist — options involving significant tradeoffs among different possible outcomes of each treatment. (Some people will prefer to accept a small risk of death to improve their function; others won't.) Decisions about these interventions — whether to have them or not, and which ones to have — should thus reflect patients' personal values and preferences and should be made only after patients have enough information to make an informed choice in partnership with their provider. https://www.dartmouth-hitchcock.org/supportive-services/decision_making_help.html

   There is a strong body of evidence that shows significant regional variation in preference-sensitive care and that this variation is not due to patient choice but rather to prevailing practice patterns. There is a growing body of evidence that when patients are engaged in decision making and provided with the information they need to think through options of care, there is a better match between the care they receive and their health goals and values.

More information is available at:

http://www.dartmouthatlas.org/keyissues/issue.aspx?con=2938
https://www.cochrane.org/news/featured-review-decision-aids-help-people-who-are-facing-health-treatment-or-screening

It is common practice to offer patients information about tests or treatment options for which there is clear evidence for a recommended action (e.g., immunization or United States Preventive Service Task Force recommended screening). However, Milestone 4 is focused on engaging patients in making choices when the evidence does not present a clear best choice and the "right" treatment or test is the one that best fits their health goals and values.

5. What is Culturally-Sensitive Care?

   Recognize, when appropriate, the client's healing beliefs and practices and explore ways to incorporate these into the treatment plan. Negotiate a treatment plan that weaves the client's cultural norms and lifeways into treatment goals, objectives, and steps.

   https://www.ncbi.nlm.nih.gov/books/NBK248423/

   https://www.ncbi.nlm.nih.gov/books/NBK64076/

6. What is Health Equity?

   The Robert Wood Johnson Foundation provides the following definition: "Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

   https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html

7. What is a Decision Aid?

   Decision Aids are interventions designed to support patients' decision making by explicitly displaying the options of the decision, providing information about treatment or screening options and their associated outcomes, compared to usual care and/or alternative interventions (Cochrane Database of Systematic Review).

   Decision aids provide:

   - High-quality, up-to-date information about the condition, including risks and benefits of available options and, if appropriate, a discussion of the limits of scientific knowledge about outcomes
   - Values clarification to help patients sort out their values and preferences

   Effective decision aids are not simply informational or instructional. The information in an effective decision aid serves to help patients explore the different options for care and the tradeoffs involved and identify their own health goals and values, supporting shared decision making.

8. Implementing decision aids should blend into your practice's workflow. To begin, it may be helpful to build a team to help answer the following questions:

    - What are some of the more common or important conditions in which you engage your patients in decisions about preference-sensitive care?
    - What decision aids will help meet this need?
    - What format is mostly likely to appeal to your patients?
    - How and who will identify eligible patients for the use of decision aids?
    - Where will the decision aids be stored?
    - How and when will the patient use decision aids?
    - How will your practice know if the process needs to be expanded, changed or refined?

Milestone 4 Resources: Patient Centered Interactions

https://www.healthit.gov/sites/default/files/nlc_shared_decision_making_fact_sheet.pdf

https://www.ahrq.gov/cahps/quality-improvement/improvement-guide/6-strategies-for-improving/communication/strategy6i-shared-decisionmaking.html

https://patientengagementhit.com/news/3-best-practices-for-shared-decision-making-in-healthcare

https://www.cdc.gov/nccdphp/dnpao/state-local-programs/health-equity/pdf/toolkit.pdf

https://www.cdc.gov/nccdphp/dch/pdf/HealthEquityGuide.pdf

https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/SDOH-workbook.pdf

Milestone 4 Reporting: Patient Centered Interactions

4A.1 Patient Experience – Patient-Centered Interactions [Quarterly] [X, #, N]

1. In Quarter 1, your practice will select the assessment method(s) that will be used (please note: this selection cannot be changed in subsequent quarters):

    - Conduct a monthly practice-based survey of their patients,
    - Create and conduct a PFAC quarterly
    - Conduct a practice-based survey and conduct a PFAC on a semi-annual basis

2. If you conducted the monthly or semi-annual practice-based survey, please report:

    - How is the survey being conducted?
    - What population is receiving the survey?
    - How many surveys were sent out and how many of those were returned?

3. If you conducted the quarterly or semi-annual PFAC, please report:

    - How many people attended the PFAC and identify roles: patient, family member, practitioner or other

4. For both the practice-based survey and the PFAC, please report:

    - A narrative of what QI efforts **will be implemented as a result of the PFAC and/or practice-based survey**.

4A.2 Patient Experience – Shared Decision Making [Quarterly] [#, N]

1. Identify at least TWO health conditions, decisions, or tests of focus for which your practice is implementing shared decision making. Select two to five options.

    The following list contains some common preference-sensitive conditions for your practice to consider. Ideally, your practice is focusing on an area that is important to the patients in your practice and for which you can acquire an aid/tool. Many of these example conditions are specific opioid and chronic disease management.

    - Management of acute low back pain (with red flags)
    - Antibiotic overuse for upper respiratory infection
    - Management of anxiety or depression
    - Management of asthma
    - Management of chronic back pain
    - Management of chronic pain
    - Management of congestive heart failure
    - Management of COPD
    - Medications in diabetes
    - Electrocardiogram and cardiac stress testing
    - Care preferences over the life continuum
    - Colon cancer screening
    - Management of heart failure

- Management of coronary heart disease
- Management of Peripheral Artery Disease
- Managing health concerns of older adults
- Chronic, Stable Angina
- Management of Trigger Finger
- Lung cancer screening in smokers
- Management of tobacco cessation
- Management of Obesity
- Other

2. For the priority area selected above, please identify the producers of the decision aids that your practice will use:

    - Agency for Health Care Research Quality (AHRQ) and Health Dialog/Informed Medical Decision
    - Center for Disease Control (CDC)
    - Healthwise Decision Points
    - Emmi Solution
    - Mayo Clinic
    - Food and Drug Administration (FDA)
    - Other

3. For each area of priority selected, indicate the counts or percentage of eligible patients who received a decision aid for the selected area of focus. This rate should increase over time as your practice works to implement this decision aid.

    Please select your preference for reporting:

    - Report as a count
    - Report as a rate

    For practices who chose to report as a count: (Report number of eligible patients who received a decision aid)

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Number of eligible patients who received a decision aid				

    For practices who chose to report as a rate: (Report percent of eligible patients who received the decision aid)

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Percent of eligible patients who received the decision aid				

Milestone 4: Terms and Conditions: Patient Centered Interactions

A. Conduct practice-based survey - monthly

B. Create PFAC - quarterly

C. Conduct survey and PFAC - semi-annually

D. Identify and implement shared decision-making tools or aids in two to five health conditions, decisions or tests. Make the decision aid available to the appropriate patients and generate metrics for the proportion of patients who received the decision aid.

E. Provide quarterly counts of patients receiving the decision aids and show growth in use of the aids

MILESTONE 5

Milestone	Milestone Category	Reporting Quarter	Reporting Method
5A.1	Quality Improvement Team Engaged Leadership, Quality Improvement Strategy	Q1-4	N
5A.2	Clinical Quality Metrics	Q1-4	X, #
5A.3	Practice Transformation Implementation Workplan	Q1-4	X

Milestone 5 Intent: Quality Improvement

The intention of Milestone 5 is to help your practice take a systematic, EHR-based approach to using data from and about your practice to drive quality improvement. In PY 2019, your practice will identify measures for quality and utilization that are important to your practice and patients. Your practice will use these measures as guides while you test changes in your practice EHR-based Clinical Quality Measures (CQM).

Starting 2019, your practice's ability to report CQMs will affect your eligibility to receive incentives gained by your GCACH set project area metrics and as well as value-based reimbursement metrics for your region. Thus, the work in this milestone this year is both to report the CQMs at the end of the year and to pay attention to your CQM data as the year progresses. Your practice will need to know that at the end of the year you can demonstrate better care and improved health outcomes for your patients as reflected in the CQMs.

The CQM reporting requirements themselves are covered in Appendix B **- Benchmark data will be required in quarters 1-2 in PY 2019.**

Milestone 5 Implementation Guide: Quality Improvement

Milestone 5 requires that your organization create a Quality Improvement team. This QI team will be dedicated to achieving the GCACH milestones and working with the Practice Transformation Navigators. The team members should include but are not limited to: C-suite level leaders, members of senior leadership such as Vice Presidents, EHR superusers, Quality Improvement Directors, providers, Medical Assistants, and front office staff. The Quality Improvement team will be defined in the Practice Transformation Implementation Workplan (PTIW) to drive quality improvement efforts.

Reviewing and Learning from Your CQM Data

In addition to the CQM reporting itself, this year's Milestone 5 also asks your quality improvement team to make a specific, regular study of your PTIW and CQM data in PY 2019, Quarters 3-4. To use what you learn to make practice improvements, we are asking that you get into the regular practice of reviewing CQMs on some regular cycle with the staff, providers, leadership, and quality improvement team. This activity is separate from the first annual CQM reporting itself. In contrast to the annual CQM reporting, which must take place in a very specific way, the review/learning process around the CQMs could be

carried out in a variety of different ways. We ask that you pull CQM data for your whole practice, if possible, as well as at the practitioner or care team level – a useful analysis for quality improvement. CQMs will be reported annually for the first year at the practice level. It is up to your practice to design a schedule and process by which you are reviewing the data. Each time you document your improvement work in the GCACH Reporting Platform, we ask you which CQMs (picking at least three) you decided to focus on. You may decide to focus on the same CQMs throughout the year or change your focus over time.

Using this CQM data to guide improvement in care may require new roles or functions within the practice to extract the data from the EHR and present it in an actionable format. This might occur at the system level for practices that are part of a larger system. As your practice attends to this milestone, you will need to establish clear data collection and distribution roles among the team, if these are not already in place. Practice providers and teams need to be familiar with reading and interpreting their team and practice level data. Having such a skill will increase the probability that the staff will act on the data to guide improvement.

Note on Milestone 5 terminology: Milestone 5 asks you to "Provide panel (provider or care team) reports on at least three measures, at least quarterly, to support improvement in care". This use of the word "reports" has been understandably confusing to some practices and EHR vendors. What we mean here is:

- Report the EHR clinical quality measures required for your region.
- Provide panel (provider or care team) reports on at least three measures at least quarterly to support improvement in care.

The concept described above of the practice staff regularly pulling, reviewing and learning from at least three CQM data. You are required to attest that you are pulling, reviewing, learning from the data, and reporting.

Use Data to Guide Improvement

Milestone 5 is intended to help you take a systematic approach to using data from your practice and about your practice to improve care. In the PY 2019, you will identify measures for quality and utilization that are important to your practice and your patients, and used that measure as a guide while you test changes in your practice. In PY 2020, the work in this milestone supports your continued work to improve quality of care as measured by CQMs.

Milestone 5 Resources: Quality Improvement

https://www.samhsa.gov/section-223/quality-measures

https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf

https://www.hca.wa.gov/assets/program/vbp_roadmapw-ah.pdf

https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-metrics#dsrip-outcome-metrics

https://www.safetynetcenter.org/en/educational-resources/quality-improvement/

http://www.safetynetmedicalhome.org/change-concepts/quality-improvement-strategy

Milestone 5 Reporting: Quality Improvement

5A.1 Quality Improvement Team Engaged Leadership, Quality Improvement Strategy [Quarterly] [X]

1. The organization will attest to operating an internal QI Team that includes organizational clinicians, IT, senior leadership, finance, etc. that meets no less frequently than monthly.

5A.2 Clinical Quality Metrics [Quarterly] [X, #, N]

1. For this milestone, your practice is required to provide practitioner or care team reports on at least three measures at least quarterly to support improvement in care. **In this past quarter, for which quality measures did your practitioner(s) or care team(s) focus their quality improvement activities?** Select all that apply in the list in Appendix B.
2. Your practice should review all CQMs for your entire practice site on a regular basis
    - Weekly
    - Monthly
    - Quarterly
    - Our EHR cannot support practice site level reports.
3. Identify who in your practice does the work of making data from the EHR available to guide and inform efforts to improve care and utilization, either on a systematic basis (provider or practice quality or utilization reports) or to answer a specific question that might arise (e.g., "Who are my patients with an A1C greater than 9%?").
    - Dedicated data analyst(s)
    - Medical records staff
    - Clinic Manager
    - Physician
    - PA
    - APRN/NP
    - RN
    - LPN
    - MA
    - Other Care Manager
    - Other (specify)
4. Your practice should regularly create individual practitioner or care team CQM reports. Identify how often your practice's individual practitioners and/or care teams review panel-specific CQM data.
    - Weekly

- Monthly
- Quarterly
- Our practice cannot create panel-specific CQM reports

5A.3 Practice Transformation Implementation Work Plan [Quarterly]

1. Actively engage with your Practice Transformation Navigator to implement and update the PTIW document throughout the demonstration.

Milestone 5 Terms and Conditions: Quality Improvement

A. A quality improvement team defined in the Practice Transformation Implementation Workplan to drive quality improvement efforts.

B. The Clinical Quality Metrics (See Appendix B) for the projects as identified by the organization.

C. Actively engage with your Practice Transformation Navigator to implement and update document throughout the demonstration. (PTIW).

MILESTONE 6

Milestone	Milestone Category	Reporting Quarter	Reporting Method
6A.1	Care Coordination Across the Medical Neighborhood	Q1-4	X, #, N

Milestone 6 Intent: Care Coordination

The work in Milestone 6 is to develop systematic coordination of care across the medical neighborhood. In PY 2018/2019, practices will reach out to willing partners. In PY 2020, your practice will take a more systematic approach when working with hospitals, EDs and specialists to bridge seams of care for your patients as they transition between settings and across the medical neighborhood providers.

The three care coordination strategies in this milestone all have the potential to improve care and reduce harm and cost. Due to the uniqueness of your practice some strategies may offer greater opportunities than others.

Milestone 6 Implementation Framework: Care Coordination

Milestone 6 encourages your practice to expand its view of what happens to your patients outside of the primary care office as they receive care from other health care entities in the community. Your practice will need to establish reliable flows of information from EDs and hospitals so you can track your patients receiving care at those settings and follow up with them after the ED visit or hospitalization. A possible tool could be the Collective Medical Platform, which includes Emergency Department Information Exchange (EDIE), PreManage and Direct Secure Messaging (DSM). This follow-up contact is likely to require new workflow processes in your practice.

Another important opportunity for coordinating care lies in creating care compact or agreements that outline respective responsibilities in care and establish reliable exchange of clinical data to guide care with referral specialists. It makes most sense to start with specialists with whom the practice shares a large number of patients.

It is worth noting that the development of medication management strategies and building of care management capacity in Milestone 2 can play an important role in the work of Milestone 6 as your practice makes plans to strengthen care coordination with specialists, EDs and/or hospitals.

The goal for care coordination across the medical neighborhood is that your practice tracks the number of patients who received a follow-up contact from your practice within one week of discharge from a target ED. A target ED is defined as a facility for which your practice can receive regular and timely information about your patient population's ED discharges. Your practice should contact patients within one week of discharge from the ED.

The work in Milestone 6 is to develop systematic coordination of care across the medical neighborhood. In PY 2018/2019, you will reach out to willing partners. In PY 2020, you will take a more systematic

approach, working with hospitals, EDs, and specialists to close the seams of care for your patients as they transition between settings and providers.

Milestone 6 Resources: Care Coordination

http://19zoo424iy3o1k9aew2gw2ir-wpengine.netdna-ssl.com/wp-content/uploads/2018/03/CareCompact.Wright.pdf

https://innovation.cms.gov/Files/x/cpcipsl-rc2.pdf

https://www.integration.samhsa.gov/operations-administration/Colorado_Primary_Care_-_Specialty_Care_Compact.pdf

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

https://www.ncbi.nlm.nih.gov/pubmed/24962967

IHI How-to-Guide:
http://www.ihi.org/resources/Pages/Tools/HowtoGuideImprovingTransitionsHospitaltoOfficePracticeReduceRehospitalizations.aspx

This Guide supports practice-based teams and their community partners in co-designing and reliably implementing improved care processes to ensure that patients who have been discharged from the hospital have an ideal transition back to the care team in the practice.

Care Coordination Agreements: https://www.ncbi.nlm.nih.gov/pubmed/17873667

Semi-structured interviews with participating providers and national thought leaders in care coordination were reviewed to develop key themes to solutions for effective agreements. Findings include that care coordination agreements were most successful in settings where providers had established communications (person-to-person or electronically) as well as existing working relationships.

Chen, AH, Improving the Primary Care-Specialty Care Interface Arch Intern Med 2009;169:1024-1025 Available at: https://www.ncbi.nlm.nih.gov/pubmed/19506170.

Chen, AH, Improving Primary Care – Specialty Care Communication: Lessons From San Francisco's Safety Net: Comment on "Referral and Consultation Communication Between Primary Care and Specialist Physicians" Arch Intern Med 2011;171(1):65-67 Available at: https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/226367.

Milestone 6 Reporting: Care Coordination

6A.1 Care Coordination Across the Medical Neighborhood [Quarterly] [X, #, N]

Please attest that your practice is using at least one of the following tools: EDIE, PreManage and/or Direct Secure Messaging.

- Yes
- No

Building on your practice's PY 2018/2019 activities, select two of the following care coordination options. Further detail on the requirements of each option is below. Please note: The selection made in Quarter 1 cannot be changed in subsequent quarters.

- **Option A**: Track the percent (%) of patients with ED visits who received follow-up contact within one week of discharge.
- **Option B:** Contact at least 75% of patients who were hospitalized in target hospital(s) within 72 hours of discharge.
- **Option C:** Enact care compacts/collaborative agreements with at least two groups of high-volume specialists in different specialties to improve coordination and transitions of care.

1. Option A: Follow-up contact with patient within one week of ED discharge.

Numerator: Number of your patients that received a follow-up contact after ED discharge within one week

Denominator: Number of your patients discharged from the target ED during this quarter

Name of ED	Numerator	Denominator

On a quarterly basis, identify the methods that your practice uses for obtaining ED discharge information. Select all that apply:

- Phone
- Fax
- Email
- Health Information Exchange
- Collective Medical Platform (e.g., Emergency Department Information Exchange, (EDIE), PreManage)
- Other

2. Option B: Conduct follow-up contact within 72 hours of hospital discharge.

The Medicaid Transformation Project goal for care coordination across the medical neighborhood is that your practice contacts **at least 75% of patients within 72 hours of discharge from one or more target**

hospital(s). A target hospital is defined as a facility from which your practice can receive regular and timely information about your patient population's hospitalizations.

Identify the hospital(s) of focus and the counts for tracking your practice's follow-up contact with discharged patients. Estimate these counts, if necessary.

Numerator: Number of your patients who received follow-up contact within 72 hours after discharge

Denominator: Number of your patients discharged from the target hospital during this quarter

Name of Hospital	Numerator	Denominator

On a quarterly basis, identify the methods that your practice uses for obtaining hospital discharge information. Select all that apply:

- Phone
- Health Information Exchange
- Fax
- Email
- Collective Medical Platform
- Other

3. Option C: Enter care compacts/agreements with at least two high-referral community partners and/or natural community partners.

Your practice indicated that it has enacted Care Compact and Agreements with at least two groups of high-referral Community Partners and/or Natural Community Partners in different specialties to improve the coordination and transitions of care for your patient population. Identify the Community Partners and/or Natural Community Partners types with whom you have arranged these care compacts/ collaborative agreements. Select all that apply and select at least two from the following options:

- Allergy
- Behavioral Health
- Cardiology
- Dermatology
- Endocrinology
- Gastroenterology
- Health Homes
- Hematology
- Infectious Disease
- Nephrology
- Neurology
- Obstetrics/Gynecology
- Oncology
- Ophthalmology
- Orthopedic Surgery
- Pain Management
- Podiatry
- Pulmonology
- Psychiatry
- Urology
- Radiology & Imaging
- Rheumatology
- SNFs
- Social Services
- SUD Providers
- Other

Please note**:** Retain a copy of the signed care compacts/collaborative agreements that your practice has with the high-referral Community Partners and/or Natural Community Partners in your community.

Milestone 6 Terms and Conditions: Care Coordination

A. ED Care- quarters 1-4 you will implement EDIE and actively engage with PreManage to track - ED discharge data. In quarters 3-4 you will report tracking data on patients that had follow-up contact within one week.

B. Follow up on hospitalization- Implement EDIE, and actively engage with PreManage to identify patient hospitalizations and obtain discharge information. In quarters 3-4, report on those receiving hospital follow-up contact within 72 hours of discharge, minimum 75% of inpatients.

C. Enact care compacts/collaborative agreements with at least two groups of high-referral specialists in different specialties to improve transitions of care. For example, primary care to cardiology, gastroenterology, orthopedics and sub-acute services, or a skilled nursing facility.

MILESTONE 7

Milestone	Milestone Category	Reporting Quarter	Reporting Method
7A.1	Participation in the Learning Collaborative	Q4	X, N

Milestone 7 Intent: Participation in Learning Collaboratives

Milestone 7 captures the work involved in participating in your region's learning collaboratives. Your practice has a responsibility to actively share in the learning with other practices, regionally and nationally. In the learning collaborative, at least one provider must be present.

Milestone 7 Implementation Guide: Participation in Learning Collaboratives

Practice transformation is challenging work. The changes required by the PY 2018/2019 milestones require a committed and coordinated care team with strong and engaged clinical and administrative leadership. Your efforts to change the way your practice works will be more successful if you engage the entire care team in your practice transformation efforts. This requires time to meet as a team and the invitation for all members of the team to contribute ideas and participate in planning for changes in practice workflow and processes supported by leadership.

Participation in regional and national educational offerings also support your practice transformation efforts. A review of the Toolkit's change concepts (page 4) will help you determine the most appropriate practice representative who should attend these offerings.

Additionally, GCACH is providing learning sessions based on the change concepts throughout 2019, and we will provide opportunities through the monthly Leadership Council meetings to expand knowledge around practice transformation concepts.

Ideally, all members of your practice leadership and QI team should attend the in-person sessions held by GCACH. Equally important is the peer-peer learning that takes place when practices share what works and what does not work on national and regional web-based and in-person meetings. This type of collaboration accelerates the pace of learning and innovation that is essential to the success of the Medicaid Transformation Project initiative.

Milestone 7 Resources: Participation in Learning Collaboratives

http://www.safetynetmedicalhome.org/change-concepts/engaged-leadership

Milestone 7 Reporting: Participation in Learning Collaboratives

7A.1 Participation in the Learning Collaborative [Quarter 4] [X, N]

Milestone 7 captures the work involved in participation in both your region's state and national learning collaboratives; each practice has a responsibility to actively engage and share in the learning with other practices, regionally and nationally. For each activity in the following list, practices will attest to whether your practice met the requirements for participation. If your practice was not able to complete one or more of the activities, please indicate the reason.

1. Participated in at least one learning session in your region per month.
    - Our Practice Site participated in the above activities during PY 2018/2019.
    - Our Practice Site DID NOT participate in the above activities during PY 2018/2019 – provide explanation.

    Or

    Participated in at least one learning webinar per month.
    - Our Practice Site participated in the above activities during PY 2018/2019.
    - Our Practice Site DID NOT participate in the above activities during PY 2018/2019 – provide explanation.

2. Contribute a minimum of one document of experiential story spotlighting success over the year.
    - Our Practice Site participated in the above activities during Program Year 2018/2019.
    - Our Practice Site DID NOT participate in the above activities during Program Year 2018/2019 - provide explanation.

3. Fully engage with the GCACH Practice Transformation Team, including regular status information as requested, for the purposes of monitoring progress toward milestone completion and/or for the purposes of providing support to meet the milestones.
    - Our Practice Site participated in the above activities during Program Year 2018/2019.
    - Our Practice Site DID NOT participate in the above activities during Program Year 2018/2019 - provide explanation.

4. Please attest that member(s) of your QI and/or clinical teams participated in at least four Leadership Council meetings. Attest that at least one provider attends at least four learning collaboratives provided by GCACH. Please provide names and titles of those individuals attending the above.

Milestone 7 Terms and Conditions: Participation in Learning Collaboratives

A. In Quarter 4, your practice will attest to participating in at least one learning session/webinar per month.

B. Attended at least four Leadership Council Meetings.

C. Attended at least four learning collaboratives with at least one provider present.

MILESTONE 8

Milestone	Milestone Category	Reporting Quarter	Reporting Method
8A.1	Health Information Technology	Q1	N

Milestone 8 Intent: Health Information Technology

The work in Milestone 8 uses a framework for optimal use of your electronic health record in the care of your patients. Milestone 8 requires that all eligible professionals within your practices successfully optimizes their EHR, in line with the most up-to-date Office of the National Coordinator certification (ONC) standards. Demonstrating achievement of Milestone 8 requires that practices use this program as a framework for optimal use of your electronic health record in the care of patients.

Milestone 8 Implementation Framework: Health Information Technology

Health Information Technology offers powerful tools that are essential to providing comprehensive primary care practices that invest in the changes in workflow necessary to use the EHR effectively can realize the promise of this technology. The registry functions can track patients with increased needs or at increased risk. Automated reminders, alerts and prompts help care teams proactively plan for preventive care and for care of chronic conditions.

Templates in the EHR embed decision support into care and help capture key clinical data as structured data. Efforts to improve data within the EHR will ensure that clinical quality measurement derived from the EHR truly reflects the quality of care provided in the practice. Regular feedback about important care processes and health outcomes using reports generated from the EHR gives providers and care teams the tools they need to improve care for their patients.

Patient portals offer tools for support of self-management, engagement of patients in shared decision making, and increased access to the provider and care team. The emergence of health information exchange in ACH regions improves the quality of the data available in primary care to manage care of the patient and enhance coordination of care the medical neighborhood.

Milestone 8 Resources: Health Information Technology

https://www.healthmgttech.com/technology-will-drive-future-population-health-management

https://www.healthcareitnews.com/news/10-technologies-support-population-health-initiatives

https://healthcare.cioreview.com/cxoinsight/the-crossroad-of-population-health-and-information-technology-nid-23700-cid-31.html

Milestone 8 Reporting: Health Information Technology

8A.1 Health Information Technology (PCMH/MeHAF Assessments) [Quarter 1] [X]

1. In the first quarter, your practice will indicate that you are using an ONC-certified EHR. In subsequent quarters, your practice will have ability to exchange health information and attest that all eligible professionals have successfully identified the settings in which you are able to exchange electronic patient information securely to other entities (i.e., direct secure messaging, patient portal, etc.).

    - Yes, we are using an ONC-certified EHR
    - No, we are not using an ONC-certified EHR

2. The ability to exchange electronic health information is emerging in many and offers your practice a powerful tool for providing comprehensive primary care while improving care and health outcomes at lower cost. Please indicate with which settings you are able to securely exchange patient information. Select all that apply:

    - Acute care hospital/ED
    - Urgent care center
    - Rehabilitation hospital
    - Specialty hospital
    - Skilled nursing facility
    - Social service agencies
    - Other long-term care facility
    - Ambulatory surgery center
    - Other health clinics/physician offices
    - Home health/hospice
    - Public health department
    - Pharmacy
    - Other

3. Please attest that your practice worked with the Practice Transformation Navigators to identify infrastructure, resources, etc., that will be required for the period of the Medicaid Transformation Project.

Milestone 8 Terms and Conditions: Health Information Technology

In the first quarter, your practice will work with the Practice Transformation Navigator to identify infrastructure, resources, etc., that will be required for the period of the MTP.

APPENDIX A – PCMH BUDGET TEMPLATE

Incentive Funding	
Planned Use of Funding	**Planned Budget**
New billing or electronic health record system	
Technical assistance	
Operating expenses for Quarter 1 2019	
Recruitment and retention of staff	
Improvements to provider network	
Staffing	
Quality improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other (specify)	
TOTAL:	**$**

Incentive Funding	
Actual Use of Funding	**Actual Cost**
New billing or electronic health record system	
Technical assistance	
Operating expenses for Quarter 1 2019	
Recruitment and retention of staff	
Improvements to provider network	
Staffing	
Quality improvement	
Support to implement integrated clinical models	
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	
Other (specify)	
TOTAL:	**$**

APPENDIX B – LIST OF CLINICAL QUALITY METRICS

1	Antidepressant Medication Management: Acute Phase of Treatment
2	Antidepressant Medication Management: Continuation Phase of Treatment
3	Child and Adolescents' Access to PCPs: 12-23 Months
4	Child and Adolescents' Access to PCPs: 2-6 Years
5	Child and Adolescents' Access to PCPs: 7-11 Years
6	Child and Adolescents' Access to PCPs: 12-19 Years
7	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed
8	Comprehensive Diabetes Care: Hemoglobin A1c Testing
9	Comprehensive Diabetes Care: Medical Attention for Nephropathy
10	Depression Screening and Follow-up for Adolescents and Adults
11	Follow-up After Discharge from ED for Alcohol or Other Drug Dependence: 7 Days
12	Follow-up After Discharge from ED for Alcohol or Other Drug Dependence: 30 Days
13	Follow-up After Discharge from ED for Mental Health: 7 Days
14	Follow-up After Discharge from ED for Mental Health: 30 Days
15	Follow-up After Hospitalization for Mental Illness: 7 Days
16	Follow-up After Hospitalization for Mental Illness: 30 Days
17	Inpatient Hospital Utilization (includes psychiatric)
18	Medication Management for People with Asthma (5 – 64 Years)
19	Mental Health Treatment Penetration (Broad Version)
20	Outpatient Emergency Department Visits per 1,000 Member Months: 0-17 years
21	Outpatient Emergency Department Visits per 1,000 Member Months: 18+ years
22	Patients on High-Dose Chronic Opioid Therapy by Varying Thresholds
23	Patients with Concurrent Sedatives Prescriptions
24	Percent Homeless (Narrow Definition)
25	Plan All-Cause Readmission Rate (30 Days)
26	Statin Therapy for Patients with Cardiovascular Disease (Prescribed)
27	Substance Use Disorder Treatment Penetration
28	TBD

APPENDIX C – MILESTONE REPORTING SCHEDULE

Milestone	Category	Description	Reporting Quarters				Reporting Method			Terms and Conditions
			Q1	Q2	Q3	Q4	Selection	Data	Narrative	
1A.1	Budget - Proposed	A proposed budget to perform the required work in 2019	✓				X	#		A. Submit proposed budget no later than February 15, 2019
1A.2	Budget - Reconciled	A reconciled budget to the pre-budget for 2019				✓	X	#		B. Submit reconciled budget from PY 2019 by Jan 15, 2020
2A.1	Access and Continuity	Empanel all patients to a care team or provider.	✓	✓	✓	✓		#		A. 95% Empanelment in comparison to the appropriate care team or MCO assigned provider list.
2A.2	Access and Continuity	Risk-Stratified Care Management	✓	✓	✓	✓	X	#	N	B. Out of 75% of the empaneled patients; provide care management to at least 80% of patients you identified as those at highest risk.
2A.3	Access and Continuity	2-Mandatory - Reference the Toolkit for menu of items.	✓	✓	✓	✓	X		N	C. Select additional opportunities from the Toolkit to enhance your care team to care for those at highest risk.
			✓	✓	✓	✓	X		N	D. Select additional opportunities from the Toolkit to enhance your care team to care for those at highest risk.
2B.1	Care Coordination	Bi-Directional Integration of Behavioral Health		✓		✓	X		N	E. Implement Bi-Directional Integration: Choose one evidence-based model of care and an evidence-based instrument or tool to systematically assess patients and monitor or adjust care.
2B.2	Care Coordination	Self-Management support for at least three high-risk conditions (Choose one of the four options)	✓	✓	✓	✓	X	#	N	F. All members of the care team have basic communication skills to support patient self-management. The practice routinely uses tools and techniques that reinforce patient self-management skills. The practice routinely and systematically assesses the self-management skills and needs for patients with chronic conditions. The practice has a systematic approach to identifying patients with a need(s) for additional support in self-management. The practice has a training strategy to develop staff/care team capacity to support self-management.
			✓	✓	✓	✓			N	G. The practice is able to measure how self-management support strategies affect target conditions or diseases, and adapts and improves these strategies to improve care outcomes.
			✓	✓	✓	✓			N	H. The practice uses tactics and tools that support self-management across conditions and supports patient acquisition of specific skills for management of target conditions or diseases: Conduct routine interval follow-up with patients about their goals and plans.
			✓	✓	✓	✓			N	I. The practice develops and maintains formal and informal linkages to external resources to support self- management. The practice will develop infrastructure and planning via narrative reporting in quarters 1-2, and a systematic narrative for reporting in PY 2020, quarters 3-4.
2B.3	Care Coordination	Medication Management and Review	✓	✓	✓	✓	X	#	N	J. The practice has a systematic approach to reconcile all patients' medications and identify high- risk patients that would benefit from medication management. Selection and narrative quarters 1-2 and data quarters 3-4.
3A.1	24/7 Access by Patients and Enhanced Access	Expand patient access to the practice by providing care and consultation outside the office visit.	✓	✓	✓	✓			N	A. Attest that the patients continue to have 24/7 access to a care team practitioner who has real-time access to the EHR.
			✓	✓	✓	✓	X		N	B. Enhance access by implementing at least one type of opportunity for care provided outside of office visits.
			✓	✓	✓	✓		#		C. Staff time spent on care provided outside of visits
			✓	✓	✓	✓	X	#		D. Commitment to timely responses
4A.1	Patient-Centered Interactions	Place the patient and family at the center of care. Your practice will use the Patient and Family Advisory Council and/or brief, in-office surveys to understand the patient perspective and engage patients and families as valuable partners. (Choose 1)	✓	✓	✓	✓	X	#	N	A. Conduct practice-based survey - monthly.
				✓	✓	✓	X	#	N	B. Create Patient and Family Advisory Council - quarterly.
				✓		✓	X	#	N	C. Survey and PFAC - semi-annually.
4A.2	Patient-Centered Interactions	Shared Decision Making- support patients as engaged, informed and effective partners in their own health.	✓	✓	✓	✓		#	N	D. Identify and implement shared decision-making tools or aids in at least 2-5 health conditions, decisions or tests. Make the decision aid available to the appropriate patients and generate metrics for the proportion of patients who received the decision aid.
			✓	✓	✓	✓		#	N	E. Provide quarterly counts of patients receiving the decision aids and show growth in use of the aids using graphs or run charts.
5A.1	Quality Improvement	Your practice will implement a "transformation project" quality improvement team to implement transformation work.	✓	✓	✓	✓	X			A. A quality improvement team defined in the Practice Transformation Implementation Work Plan to drive quality improvement efforts.
5A.2	Quality Improvement	A systematic approach to using data about your practice to drive quality improvement. You will begin to work toward metrics related to the project areas and metrics related to the success of value-based reimbursement	✓	✓	✓	✓	X	#		B. The Clinical Quality Metrics for the projects as identified by your organization in Appendix B.
5A.3	Quality Improvement	Practice Transformation Implementation Workplan. Develop a framework and plan for achieving all milestones and self-identified goals and/or projects. This is a "living" document that will be updated regularly.	✓	✓	✓	✓	X			C. Actively engage with your Practice Transformation Navigator to implement and update document throughout the demonstration. (PTIW)
6A.1	Care Coordination across the Medical Neighborhood	A systematic coordination of care across the medical neighborhood. Practice will take a more systematic approach to working with Emergency Departments, specialists, hospitals, etc. to bridge seams of care between settings. (First Quarter - Select two of the three options for milestone 6)	✓	✓	✓	✓	X	#		A. ED Care- quarters 1-4 you will implement EDIE and actively engage with PreManage to track - ED discharge data. In quarters 3-4 you will report tracking data on patients that had follow-up contact within one week.
			✓	✓	✓	✓	X	#		B. Follow up on hospitalization- Implement EDIE, and actively engage with PreManage to identify patient hospitalizations and obtain discharge information. In quarters 3-4, report on those receiving hospital follow-up contact within 72 hours of discharge, minimum 75% of inpatients.
			✓	✓	✓	✓	X		N	C. Enact care compacts/collaborative agreements with at least two groups of high-referral specialists in different specialties to improve transitions of care including primary care to cardiology, gastroenterology, orthopedics and sub-acute services (for example, a skilled nursing facility).
7A.1	Learning Collaboratives / Trainings / Mentoring	Participation in the Medicaid Transformation Project Team Learning Collaboratives, Training and for Exemplar clinics- mentoring.				✓	X		N	A. In Quarter 4, your practice will attest to having participated in at least one learning session/webinar per month.
						✓	X		N	B. Attended at least four Leadership Council Meetings.
						✓	X		N	C. Attended at least 4 learning collaboratives with at least one provider present.
8A.1	Health Information Technology	Develop a framework for optimal use of your electronic health record in the care of your patients, meeting metrics and use IT dollars to invest in resources where necessary.	✓						N	A. In the first quarter, your practice will work with the Practice Transformation Navigator to identify infrastructure, resources, etc. that will be required for the period of the Medicaid Transformation Project.

APPENDIX C – MILESTONE REPORTING SCHEDULE

Milestone	Category	Description	Reporting Quarters				Reporting Method			Terms and Conditions
			Q1	Q2	Q3	Q4	Selection	Data	Narrative	
1A.1	Budget - Proposed	A proposed budget to perform the required work in 2019	✓				X	#		A. Submit proposed budget no later than February 15, 2019
1A.2	Budget - Reconciled	A reconciled budget to the pre-budget for 2019				✓	X	#		B. Submit reconciled budget from PY 2019 by Jan 15, 2020
2A.1	Access and Continuity	Empanel all patients to a care team or provider.	✓	✓	✓	✓		#		A. 95% Empanelment in comparison to the appropriate care team or MCO assigned provider list.
2A.2	Access and Continuity	Risk-Stratified Care Management	✓	✓	✓	✓	X	#	N	B. Out of 75% of the empaneled patients; provide care management to at least 80% of patients you identified as those at highest risk.
2A.3	Access and Continuity	2-Mandatory - Reference the Toolkit for menu of items.	✓	✓	✓	✓	X		N	C. Select additional opportunities from the Toolkit to enhance your care team to care for those at highest risk.
			✓	✓	✓	✓	X		N	D. Select additional opportunities from the Toolkit to enhance your care team to care for those at highest risk.
2B.1	Care Coordination	Bi-Directional Integration of Behavioral Health		✓		✓	X		N	E. Implement Bi-Directional Integration: Choose one evidence-based model of care and an evidence-based instrument or tool to systematically assess patients and monitor or adjust care.
2B.2	Care Coordination	Self-Management support for at least three high-risk conditions (Choose one of the four options)	✓	✓	✓	✓	X	#	N	F. All members of the care team have basic communication skills to support patient self-management. The practice routinely uses tools and techniques that reinforce patient self-management skills. The practice routinely and systematically assesses the self-management skills and needs for patients with chronic conditions. The practice has a systematic approach to identifying patients with a need(s) for additional support in self-management. The practice has a training strategy to develop staff/care team capacity to support self-management.
			✓	✓	✓	✓			N	G. The practice is able to measure how self-management support strategies affect target conditions or diseases, and adapts and improves these strategies to improve care outcomes.
			✓	✓	✓	✓			N	H. The practice uses tactics and tools that support self-management across conditions and supports patient acquisition of specific skills for management of target conditions or diseases: Conduct routine interval follow-up with patients about their goals and plans.
			✓	✓	✓	✓			N	I. The practice develops and maintains formal and informal linkages to external resources to support self- management. The practice will develop infrastructure and planning via narrative reporting in quarters 1-2, and a systematic narrative for reporting in PY 2020, quarters 3-4.
2B.3	Care Coordination	Medication Management and Review	✓	✓	✓	✓	X	#	N	J. The practice has a systematic approach to reconcile all patients' medications and identify high- risk patients that would benefit from medication management. Selection and narrative quarters 1-2 and data quarters 3-4.
3A.1	24/7 Access by Patients and Enhanced Access	Expand patient access to the practice by providing care and consultation outside the office visit.	✓	✓	✓	✓			N	A. Attest that the patients continue to have 24/7 access to a care team practitioner who has real-time access to the EHR.
			✓	✓	✓	✓	X		N	B. Enhance access by implementing at least one type of opportunity for care provided outside of office visits.
			✓	✓	✓	✓		#		C. Staff time spent on care provided outside of visits
			✓	✓	✓	✓	X	#		D. Commitment to timely responses
4A.1	Patient-Centered Interactions	Place the patient and family at the center of care. Your practice will use the Patient and Family Advisory Council and/or brief, in-office surveys to understand the patient perspective and engage patients and families as valuable partners. (Choose 1)	✓	✓	✓	✓	X	#	N	A. Conduct practice-based survey - monthly0.
				✓	✓	✓	X	#	N	B. Create Patient and Family Advisory Council - quarterly.
				✓		✓	X	#	N	C. Survey and PFAC - semi-annually.
4A.2	Patient-Centered Interactions	Shared Decision Making- support patients as engaged, informed and effective partners in their own health.	✓	✓	✓	✓		#	N	D. Identify and implement shared decision-making tools or aids in at least 2-5 health conditions, decisions or tests. Make the decision aid available to the appropriate patients and generate metrics for the proportion of patients who received the decision aid.
			✓	✓	✓	✓		#	N	E. Provide quarterly counts of patients receiving the decision aids and show growth in use of the aids using graphs or run charts.
5A.1	Quality Improvement	Your practice will implement a "transformation project" quality improvement team to implement transformation work.	✓	✓	✓	✓	X			A. A quality improvement team defined in the Practice Transformation Implementation Work Plan to drive quality improvement efforts.
5A.2	Quality Improvement	A systematic approach to using data about your practice to drive quality improvement. You will begin to work toward metrics related to the project areas and metrics related to the success of value-based reimbursement	✓	✓	✓	✓	X	#		B. The Clinical Quality Metrics for the projects as identified by your organization in Appendix B.
5A.3	Quality Improvement	Practice Transformation Implementation Workplan. Develop a framework and plan for achieving all milestones and self-identified goals and/or projects. This is a "living" document that will be updated regularly.	✓	✓	✓	✓	X			C. Actively engage with your Practice Transformation Navigator to implement and update document throughout the demonstration. (PTIW)
6A.1	Care Coordination across the Medical Neighborhood	A systematic coordination of care across the medical neighborhood. Practice will take a more systematic approach to working with Emergency Departments, specialists, hospitals, etc. to bridge seams of care between settings. (First Quarter - Select two of the three options for milestone 6)	✓	✓	✓	✓	X	#		A. ED Care- quarters 1-4 you will implement EDIE and actively engage with PreManage to track - ED discharge data. In quarters 3-4 you will report tracking data on patients that had follow-up contact within one week.
			✓	✓	✓	✓	X	#		B. Follow up on hospitalization- Implement EDIE, and actively engage with PreManage to identify patient hospitalizations and obtain discharge information. In quarters 3-4, report on those receiving hospital follow-up contact within 72 hours of discharge, minimum 75% of inpatients.
			✓	✓	✓	✓	X		N	C. Enact care compacts/collaborative agreements with at least two groups of high-referral specialists in different specialties to improve transitions of care including primary care to cardiology, gastroenterology, orthopedics and sub-acute services (for example, a skilled nursing facility).
7A.1	Learning Collaboratives / Trainings / Mentoring	Participation in the Medicaid Transformation Project Team Learning Collaboratives, Training and for Exemplar clinics- mentoring.				✓	X		N	A. In Quarter 4, your practice will attest to having participated in at least one learning session/webinar per month.
						✓	X		N	B. Attended at least four Leadership Council Meetings.
						✓	X		N	C. Attended at least 4 learning collaboratives with at least one provider present.
8A.1	Health Information Technology	Develop a framework for optimal use of your electronic health record in the care of your patients, meeting metrics and use IT dollars to invest in resources where necessary.	✓				X			A. In the first quarter, your practice will work with the Practice Transformation Navigator to identify infrastructure, resources, etc. that will be required for the period of the Medicaid Transformation Project.

PRACTICE TRANSFORMATION REPORTING WORKBOOK

GREATER COLUMBIA ACCOUNTABLE COMMUNITY OF HEALTH

GCACH Program Year 2018/2019

Practice Transformation Reporting Workbook

Please use this Practice Transformation Reporting Workbook (Workbook) as the tool to report your progress for Practice Transformation implementation activities for 2018/2019. You may edit this document to report completion of your program Milestones. Your Practice Transformation Navigator will assist you in understanding the requirements for completing this Workbook. As well, the Practice Transformation Implementation & Reporting Toolkit will guide you in interpreting and responding to the Milestones.

How to Complete This Workbook

Progress on the achievement of the Milestones can be documented in three ways: Selection, Data, and/or Narrative. Milestones that require a selection may be marked with an "X". Milestones that require data entry can be entered directly into the Workbook. Narrative entries may also be entered directly into the Workbook.

How to Return the Completed Workbook

If you choose to complete this Workbook within your organization's Dropbox folder, entries will be autosaved and updated in real time. The Practice Transformation Navigators have access to your organization's folder and will be able to see reported progress.

Deadlines for Completion

If there are any questions throughout the course of Practice Transformation, please contact one of the following members of the Practice Transformation team:

Sam Werdel, Director of Practice Transformation
Swerdel@gcach.org, 509-440-0230

Martin Sanchez, Practice Transformation Navigator
Msanchez@gcach.org, 509-537-2138

Jenna Shelton, Practice Transformation Navigator
Jshelton@gcach.org, 509-537-2136

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MILESTONE 1

Milestone	Milestone Category	Reporting Quarter	Reporting Method
1A.1	Budget - Proposed	Q1	X, #
1A.2	Budget - Reconciled	Q4	X, #

Milestone 1: Reporting

1A.1 Budget - Proposed [Quarter 1] [X, #]

In PY 2018/2019, your practice will provide an estimated budget by February 15, 2019. Please use the PCMH Budget Template for PY 2018/2019. If you have questions please contact your Practice Transformation Navigator:

Planned Use of Incentive Funding	
Planned Use of Funding	**Planned Budget**
New billing or electronic health record system	Enter amount
Technical assistance	Enter amount
Operating expenses for Quarter 1 2019	Enter amount
Recruitment and retention of staff	Enter amount
Improvements to provider network	Enter amount
Staffing	Enter amount
Quality improvement	Enter amount
Support to implement integrated clinical models	Enter amount
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	Enter amount
Other (specify)	Enter amount
TOTAL:	Enter amount

1A.2 Budget - Reconciled [Quarter 4] [X, #]

By January 15, 2020, your practice will report final funding and costs for PY 2018/2019. Please use the PCMH Budget Template for PY 2018/2019. If you have questions please contact your Practice Transformation Navigator:

Actual Use of Incentive Funding	
Actual Use of Funding	**Actual Cost**
New billing or electronic health record system	Enter amount
Technical assistance	Enter amount
Operating expenses for Quarter 1 2019	Enter amount
Recruitment and retention of staff	Enter amount
Improvements to provider network	Enter amount
Staffing	Enter amount
Quality improvement	Enter amount
Support to implement integrated clinical models	Enter amount
Staff to attend provider training, meetings, collaborative meetings (time loss from patient care)	Enter amount
Other (specify)	Enter amount
TOTAL:	Enter amount

Reconciliation of Planned Use and Actual Use budget

If the difference between the proposed budget was greater than 10% from your reconciled budget, your practice will be asked to tell us why your Actual Use budget differed from the Planned Use budget. Please report here why your Actual Use budget differed from the Planned Use budget by more than 10%:

Enter narrative if needed

MILESTONE 2

Milestone	Milestone Category	Reporting Quarter	Reporting Method
2A.1	Empanelment Status	Q1-4	#
2A.2	Risk Stratification Methodology	Q1-4	X, #, N
2A.3	Additional Opportunities for Those at Highest Risk	Q1-4	X, N
2B.1	Bi-Directional Integration of Behavioral Health	Q2, Q4	X, N
2B.2	Self-Management Support	Q1-4	N
2B.3	Medication Management	Q1-4	X, #, N

Milestone 2 Reporting: Access and Continuity

2A.1 Empanelment Status [Quarterly] [#]

Your practice will work toward maintaining at least 95% empanelment to providers or care teams in PY 2019. Provide the status of empanelment at your practice site using the following numerator and denominator.

Numerator	Total number of patients empaneled or identified in the EHR as being associated with a primary care practitioner in the practice	Enter number
Denominator	Total number of active patients	Enter number
Primary Care Practitioner or Team Panels	State the number of primary care practitioner panels or team panels at the practice site	Enter number

2A.2.a Risk Stratification Methodology and Types [Quarterly] [X, #, N]

Of the 95% of empaneled patients identified in 2A.1, the target is to achieve risk stratification of at least 75% of empaneled patients. Patients that are risk stratified will be grouped into risk categories from low to high risk. Provide care management to at least 80% of patients you identified as those at highest risk.

1. Identify the data types that your practice uses to risk stratify your patient population. The risk stratification methodology your practice develops can use multiple types and sources of data (e.g., clinical, claims, utilization, etc.). The GCACH Reporting Platform will provide a list of possible types and sources for your practice to select, including the option of adding your own data source, if not listed.

Please identify the data types that your practice uses to risk stratify. Select all that apply.

• Claims (payers)	Select if appropriate
• Clinical (practice, hospital, etc.)	Select if appropriate
• Number of ED visits	Select if appropriate
• Number of office visits	Select if appropriate
• Number of hospitalizations	Select if appropriate
• Level of costs	Select if appropriate
• Diagnosis Diabetes	Select if appropriate
• Diagnosis Congestive Heart Failure (CHF)	Select if appropriate
• Diagnosis Asthma	Select if appropriate
• Diagnosis COPD	Select if appropriate
• Diagnosis Depression	Select if appropriate
• Diagnosis Substance abuse	Select if appropriate
• Diagnosis Cancer	Select if appropriate
• Level of disease control	Select if appropriate
• Number of medications	Select if appropriate
• Publicly available algorithm, please list known criteria	Select if appropriate
• AAFP risk score	Select if appropriate
• Proprietary algorithm score, variables unknown	Select if appropriate
• Other algorithm score (specify)	Select if appropriate
• Other psychosocial or behavioral risk factors, please list	Select if appropriate

• Clinician judgment of risk	Select if appropriate
• Other (specify)	Select if appropriate

2. Using the data types above, your practice will **provide a concise narrative describing the approach, methodology or tools used to stratify patients by risk and how this information is recorded in the EHR.**

   To show support for the selected approach, your practice may also upload up to three documents, such as algorithms or policies and procedures that show your process. If your practice uploads documents, a list or summary of the documents must be added to a provided text box.

Enter narrative

2A.2.b Risk Stratification Statistics [Quarterly] [#]

Use the information in this section to record the total number of patients in each risk stratum and the number of patients within the stratum that received care management services during the reporting quarter. Your practice may enter a "0" if there are no patients in a stratum or if your risk stratification methodology does not have that many strata. Your practice will complete a new table each quarter.

	Total number of patients in stratum:	**Number of patients within the stratum that received care management:**
Highest stratum	Enter number	Enter number
Second stratum of risk	Enter number	Enter number
Third stratum of risk	Enter number	Enter number
Fourth stratum of risk	Enter number	Enter number
Low risk/no risk identified	Enter number	Enter number
Not assigned a risk	Enter number	Enter number

2A.3 Opportunities For Those at Highest Risk [Quarterly] [X,N]

1. Select two additional opportunities to enhance your care team to care for those at highest risk:

Planned Care for Chronic Conditions and Preventive Care	
• Use a personalized plan of care for each patient	Select if appropriate
• Manage medications to maximize therapeutic	Select if appropriate

benefit and patient safety at lowest cost	
• Proactively manage chronic and preventive care for empaneled patients	Select if appropriate
• Use team-based care to meet patient needs effectively	Select if appropriate
Risk-Stratified Care Management	
• Use care management pathways appropriate to the risk status of each patient	Select if appropriate
• Manage care across transitions	Select if appropriate
• Use evidence-based pathways for care	Select if appropriate
Patient and Caregiver Engagement	
• Integrate culturally competent self-management support into usual care	Select if appropriate
• Involve patient and family in decision making in all aspects of care	Select if appropriate

2. Select the care management activities that your practice uses for its patient population. Select all that apply:

• Patient coaching	Select if appropriate
• Education	Select if appropriate
• Care plan development	Select if appropriate
• Monitoring	Select if appropriate
• Home visits	Select if appropriate
• Hospital visits	Select if appropriate
• Transition management (between both sites of care and providers of care)	Select if appropriate
• Post-discharge contact	Select if appropriate
• Other (specify)	Select if appropriate

3. Describe who on your staff provides care management services. All fields in the table are required. A text field will be provided for any additional information that you may want to share with GCACH. To save time, the number of practitioners from the previous quarter will be pre-filled in the table. Enter a zero if your practice does not have the specific provider type.

Care management services are provided by:	Number of practitioners	Average patient caseload per practitioner this quarter
• APRN or Nurse Practitioner (NP)	# practitioners	Average caseload
• Medical Assistant (MA)	# practitioners	Average caseload
• Physician (MD/DO)	# practitioners	Average caseload
• Physician Assistant (PA)	# practitioners	Average caseload
• Registered Nurse (RN)	# practitioners	Average caseload
• Health Educator	# practitioners	Average caseload
• Other:	# practitioners	Average caseload

Enter Narrative

Milestone 2 Reporting: Care Coordination

2B.1 Bi-Directional Integration of Behavioral Health [Quarter 2, Quarter 4] [X, N]

1. Choose one of the three models of Behavioral Health Integration:

• Bree Collaborative	Select if appropriate
• Co-location of Primary Care and Behavioral Health	Select if appropriate

• AIMS-University of Washington Collaborative Care Model	Select if appropriate

2. Choose an evidence-based instrument or tool to systematically assess patients and monitor or adjust care.

• Adult Attention-Deficit/Hyperactivity Disorder Self-Report Scale (ASRS-v11)	Select if appropriate
• Audit-C	Select if appropriate
• Brief Pain Inventory	Select if appropriate
• Brief Psychiatric Rating Scale	Select if appropriate
• Composite International Diagnostic Interview for depression	Select if appropriate
• Drug Abuse Screen Test	Select if appropriate
• Generalized Anxiety Disorder subscale (GAD-7)	Select if appropriate
• Global Assessment of Functioning (GAF)	Select if appropriate
• Mini Mental Status Examination	Select if appropriate
• Montreal Cognitive Assessment	Select if appropriate
• Mood Disorder Questionnaire	Select if appropriate
• Patient Health Questionnaire for Depression (PHQ-2 / PHQ-9)	Select if appropriate
• Primary Care Post-Traumatic Stress Disorder Screener (PC-PTSD)	Select if appropriate
• PTSD Checklist (PCL-C)	Select if appropriate
• Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)	Select if appropriate
• Other (specify)	Select if appropriate

3. How have you organized the behavioral health services in your practice? For each of the services, identify who provides the services and how they fit into the system of care.

Services Include:

• Screening	Select if appropriate
• Evaluation/diagnosis	Select if appropriate
• Evidence-Based Treatment	Select if appropriate
• Referral coordination	Select if appropriate
• Tracking and measurement	Select if appropriate
• Family and Caregiver Support	Select if appropriate
• Peer support	Select if appropriate
• Other (describe)	Select if appropriate

After selecting each service, identify who providers this service:

• Physician	Select if appropriate
• PA	Select if appropriate
• APRN/NP	Select if appropriate
• Registered Nurse (RN)	Select if appropriate
• Licensed Practical Nurse (LPN)	Select if appropriate
• Medical Assistant	Select if appropriate
• Other Care manager	Select if appropriate
• Health educator	Select if appropriate
• Pharmacist	Select if appropriate
• Behavioral Health Specialist	Select if appropriate
• Behavioral Health Integration	Select if appropriate
• Practice care team	Select if appropriate

• Those available outside of the practice through contract or as a system resource (for practices that are within systems)	Select if appropriate
• Those available through coordinated referral in the medical neighborhood	Select if appropriate

4. Which assessment of behavioral health integration have you used to assess your practice?

• AIMS Center Patient-Centered Integrated Behavioral Health Care Principles and Tasks	Select if appropriate
• Integration Academy Self-Assessment Checklist	Select if appropriate
• Maine Health Access Foundation	Select if appropriate
• Patient-Centered Medical Home Assessment	Select if appropriate
• Other (specify)	Select if appropriate

5. How are you identifying patients in need of integrated behavioral health services? Select all that apply:

• Use of your risk stratification methodology	Select if appropriate
• Positive screen (indicate screening tool used from Question 7 below)	Select if appropriate
• The presence of a specific diagnosis (indicate diagnoses)	Select if appropriate
• Inability to reach goals in management of chronic conditions (indicate target chronic conditions)	Select if appropriate
• Other (specify)	Select if appropriate

6. Provide a concise narrative identifying how many patients are currently receiving integrated behavioral health services and being tracked in your EHR or standalone registry.

Enter Narrative

7. What evidence-based instruments or screening tools are you using to systematically assess patients and monitor or adjust care?

   Select all that apply:

• Broad measure: Brief Psychiatric Rating Scale	Select if appropriate
• Depression: Patient Health Questionnaire for Depression	Select if appropriate
• Screening, Brief Intervention, Referral to Treatment (SBIRT)	Select if appropriate
• Depression: PHQ-2, PHQ-9 mood disorders	Select if appropriate
• Mood: Mood Disorder Questionnaire	Select if appropriate
• Depression: Composite International Diagnostic Interview for depression	Select if appropriate
• Anxiety: Generalized Anxiety Disorder subscale (GAD-7)	Select if appropriate
• ADHD: Adult ADHD Self-Report Scale (ASRS-v11)	Select if appropriate
• Pain: Brief Pain Inventory	Select if appropriate
• OCD: Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)	Select if appropriate
• PTSD: PTSD Checklist (PCL-C)	Select if appropriate
• PTSD: Primary Care PTSD Screener (PC-PTSD)	Select if appropriate
• Alcohol use disorder: The Alcohol Use Disorders Identification Test (AUDIT-C)	Select if appropriate
• Drug Abuse Screen Test (DAST)	Select if appropriate
• Cognitive function: Montreal Cognitive Assessment	Select if appropriate
• Cognitive function: Mini Mental Status Examination	Select if appropriate
• Other (specify)	Select if appropriate

8. For each tool or instrument selected, identify when/how it is applied or used:

• Identifying need for care	Select if appropriate
• Follow-up and monitoring	Select if appropriate
• Engage patients in decisions about care	Select if appropriate
• Plan care	Select if appropriate
• Other (describe)	Select if appropriate

9. Identify the team members responsible for applying or using that tool. Select all that apply:

• Physician	Select if appropriate
• Other Care manager	Select if appropriate
• PA	Select if appropriate
• Health educator	Select if appropriate
• APRN/NP	Select if appropriate
• Pharmacist	Select if appropriate
• Registered Nurse (RN)	Select if appropriate
• Behavioral Health Specialist (specify what discipline)	Select if appropriate
• LPN	Select if appropriate
• MA	Select if appropriate
• Other (specify)	Select if appropriate

10. What evidence-based treatments does your practice make available to patients in addition to medications when appropriate? Select all that apply:

• Problem Solving Treatment	Select if appropriate

• Behavioral Activation	Select if appropriate
• Cognitive Behavioral Therapy	Select if appropriate
• Interpersonal Therapy	Select if appropriate
• Motivational Interviewing	Select if appropriate
• Other (specify)	Select if appropriate

11. How and when does the practice do systematic case review and consultation (review of patients in active treatment with specific recommendations for management of patients is not improving) and outreach to patients who have dropped out of treatment?

    Systemic case review and consultation:

• Weekly	Select if appropriate
• Biweekly	Select if appropriate
• Monthly	Select if appropriate

12. Who is on the review team?

• Psychologist	Select if appropriate
• Psychiatrist	Select if appropriate
• Social worker	Select if appropriate
• Physician	Select if appropriate
• PA	Select if appropriate
• APRN/NP	Select if appropriate
• Other	Select if appropriate

13. Identification and outreach to patients lost to follow up

• RN	Select if appropriate

• LPN	Select if appropriate
• Other Care Manager	Select if appropriate
• Other (specify)	Select if appropriate

14. Who does outreach?

• Psychologist	Select if appropriate
• RN	Select if appropriate
• Psychiatrist	Select if appropriate
• LPN	Select if appropriate
• Social Worker	Select if appropriate
• Other Care Manager	Select if appropriate
• Physician	Select if appropriate
• MA	Select if appropriate
• PA	Select if appropriate
• APRN/NP	Select if appropriate
• Other (specify)	Select if appropriate

15. What measures will you use to assess the integration of behavioral health and the impact of behavioral health services on your patient population? These might be measures of integration such as percentage of patients with a diagnosis of depression who are managed within the practice, key process measures such as percentage of patients with follow up within two weeks of initiating treatment, or measures of effective management, such as percentage of patients with depression who show improvement in scores on PHQ 9 over a specific period of time. (These are examples only and the identification of useful and effective measures for your practice will be a topic of the learning community.)

Enter narrative

16. How have you increased your practice capacity to implement this program in the past quarter?

• Training -MAT Training	Select if appropriate
• Hire or contract for new staff with behavioral health skills	Select if appropriate
• New referral or co-management arrangements	Select if appropriate
• None in this quarter	Select if appropriate
• Other (specify)	Select if appropriate

2B.2 Self-Management Support [Quarterly] [X, #, N]

1. Choose **one** of the four options for self-management support:

• **Option A:** The practice team embeds self-management support tactics and tools into care of all patients and has intensive strategies available for patients at increased risk: o All members of the care team have basic communication skills to support patient self-management. o The practice routinely uses tools and techniques that reinforce patient self-management skills. o The practice routinely and systematically assesses the self-management skills and needs for patients with chronic conditions and this information is used to guide support for self-management. o The practice has a systematic approach to identifying patients with a need(s) for additional support in self-management. o The practice has a training strategy (formal or on-the-job) to develop staff/care team capacity to support self-management.	Select if appropriate

• **Option B:** The practice uses tactics and tools that support self-management across conditions and supports patient acquisition of specific skills for management of target conditions or diseases. o Routine interval follow-up with patients about their goals and plans is a critical tactic for supporting patient self-management	Select if appropriate
• **Option C:** The practice is able to measure how self-management support strategies affect target conditions or diseases and adapts and improves these strategies to improve care outcomes.	Select if appropriate
• **Option D:** The practice develops and maintains formal and informal linkages to external resources to support self-management.	Select if appropriate

2. List what high-risk conditions (at least three) are the focus for self-management support in your practice and how many patients in the practice have that condition. What triggers support for self-management?

   List the triggers (below) for each condition. Indicate all that apply:

   - All patients with the condition
   - General risk status (using the practice's risk stratification methodology)
   - Poorly controlled disease
   - Data from a formal self-management assessment tool
   - Patient expression of interest
   - Other (specify)

Condition	Trigger for self-management support	Number of patients with this condition
List condition	List trigger	# patients
List condition	List trigger	# patients
List condition	List trigger	# patients
List condition	List trigger	# patients
List condition	List trigger	# patients

3. How do you provide your patients with disease or condition-specific skills for your target conditions (beyond patient education in the Evaluation and Management visits with a physician, nurse practitioner, or PA) and what are the training or credentials of the provider of disease or condition-

specific skills? How many patients received training in managing their disease or condition this quarter?

Condition	Provided by (staff or external resource)	Training or credentials	Number of patients that received the intervention this quarter
List condition	List provider	Provider training	# patients
List condition	List provider	Provider training	# patients
List condition	List provider	Provider training	# patients
List condition	List provider	Provider training	# patients

4. What cross-condition strategies does the practice use to support self-management and who is responsible? Select the approaches and techniques. Select all that apply:

   Specify the team members for each approach and technique. Select all that apply:
   - Physician
   - PA
   - APRN/NP
   - RN
   - LPN
   - Other Care manager
   - MA
   - Health Educator
   - Behaviorist
   - Pharmacist
   - Community Health Worker
   - Community Resource
   - Other (specify)

Between-visit planning and coaching	
• Pre-visit development of a shared visit agenda with the patient	Select if appropriate and specify team members
• Team preparation for the patient	Select if appropriate and specify team members
• Coaching between visits and follow up on care plan and goals	Select if appropriate and specify team members
Goal setting and Care Plan/Action Plan development	
• Discuss patient goals and document in EHR	Select if appropriate and specify team members

• Develop care plan/action plan and document plan in the EHR	Select if appropriate and specify team members
Peer support and counseling	
• Peer-led support for self-management	Select if appropriate and specify team members
• Group visits	Select if appropriate and specify team members

5. What approach are you using to assist patients in assessing their need for support for self-management? Select all that apply:

• Patient Activation Measure	Select if appropriate
• How's My Health	Select if appropriate
• In planning	Select if appropriate
• Other (specify)	Select if appropriate

6. What evidence-based counseling approaches are you using in self-management support? Select all that apply and narrative:
   For each approach, who on the care team has the training? Select all that apply:

   - Physician
   - PA
   - APRN/NP
   - RN
   - LPN
   - Other Care manager
   - MA
   - Health Educator
   - Behaviorist
   - Pharmacist
   - Community Health Worker
   - Other (specify)

• Motivational Interviewing	Select if appropriate	Trained care team member
• 5 As (5 Major steps for intervention)	Select if appropriate	Trained care team member

• Reflective Listening	Select if appropriate	Trained care team member
• Teach Back	Select if appropriate	Trained care team member
• Other (Specify)	Select if appropriate	Trained care team member

7. What specific self-management tools are you using and who on the team uses this tool? These can range from simple worksheets to help patients identify their agenda for a visit to web-based tools for the development of a shared care plan.

   List self-management tools you are using.

   For each tool listed, identify who on the team uses this tool:

   - Physician
   - PA
   - APRN/NP
   - RN
   - LPN
   - Other Care manager
   - MA
   - Health Educator
   - Behaviorist
   - Pharmacist
   - Community Health Worker
   - Other (specify)

Self-management tool	Care team member using this tool
Self-management tool	Care team member using this tool
Self-management tool	Care team member using this tool
Self-management tool	Care team member using this tool

8. What community-based resources do you make available to your patients for support for self-management and how do you link patients to this resource? Identify three to five community-based resources.

   List community-based resources you make available to your patients.

For each community-based resource, indicate how the link between the patient and the resource is made. Select one per resource:

- Information provided
- Formal referral or prescription, without feedback
- Formal referral or prescription with feedback report expected and tracked
- Other (Specify)

Community-based resource	Link between patient and resource
Community-based resource	Link between patient and resource
Community-based resource	Link between patient and resource
Community-based resource	Link between patient and resource
Community-based resource	Link between patient and resource

9. How have you added to your practice capacity for support of self-management in the past quarter?

• Training	Select if appropriate
• Hire new staff with specific training or skills (e.g., Certified Diabetes Educator (CDE))	Select if appropriate
• Contract for new staff with specific training or skills (MoU)	Select if appropriate
• None in this quarter	Select if appropriate
• Other (Specify)	Select if appropriate

10. What measures are you using to track the impact of support for self-management on care processes, health outcomes or costs for the conditions that you identified? Note that these can be the same measures tracked in Milestone 5.

Measure/Condition	Measures
Measure/Condition	Measures
Measure/Condition	Measures

Measure/Condition	Measures

11. What new capacity have you developed in your practice this quarter in provision of support for self-management?

    Select the means of adding each capacity. Select all that apply:

    - Hiring
    - Training of existing staff
    - Contracting
    - Other
    - Formal relationship with external resource

New self-management support capacity	Means of adding capacity
New self-management support capacity	Means of adding capacity
New self-management support capacity	Means of adding capacity
New self-management support capacity	Means of adding capacity

2B.3.a Medication Management [Quarterly] [X, #, N]

1. Choose one of the following that indicates how your practice accomplishes medication management and review. Provide narrative:

• **Option A:** The practice has integrated a clinical pharmacist or pharmacists as a part of the care team. The integrated pharmacist's roles and responsibilities should include the following: o Works on site o Is involved in patient care, either directly or through chart review and recommendations, and documents care in the EHR o Participates in the identification of high-risk patients who would	Select if appropriate

benefit from medication management o Participates in care team meetings o Participates in development of processes to improve medication effectiveness and safety o MAT trained clinician or referral source identified o Monitoring of the PDMP	
• **Option B:** The practice delivers comprehensive medication management services, which includes the following: o Medication reconciliation o Coordination of medications across transitions of care settings and providers o Medication review and assessment aimed at providing the safest and most cost-effective medication regimen possible to meet the patient's health goals o Development of a medication action plan or contribution to a global care plan o Medication monitoring o Support for medication adherence and self-management o Collaborative drug therapy management (when within the state's scope of practice) o Monitoring of the PDMP o MAT trained clinician or referral source identified	Select if appropriate
• **Option C:** The practice has a systematic approach to the	Select if appropriate

identification of patients to receive medication management services. Criteria could include some or all of the following: o Patients in high-risk cohorts already defined under Milestone 2 o Patients who have not achieved a therapeutic goal for a chronic condition o Patients with care transitions o Patients are systematically referenced in the PDMP at each visit and prescribing episode o Patients with multiple ED visits or hospitalizations o Patients with high-risk medications or complex medication regimens o The practice measures key processes and outcomes to improve medication effectiveness and safety	

2. What comprehensive medication management services does your practice provide? This should include medication reconciliation and additional services. Select all that apply and narrative:

• Medication reconciliation	Select if appropriate
• Coordination of medications across transitions of care settings and providers	Select if appropriate
• Medication review and assessment aimed at providing the safest and most cost-effective medication regimen possible to meet the patient's health goals	Select if appropriate
• Development of a medication action plan or contribution to a global care plan	Select if appropriate
• Medication monitoring	Select if appropriate

• Support for medication adherence and self-management	Select if appropriate
• Collaborative drug therapy management	Select if appropriate
• PDMP Monitoring	Select if appropriate
• Provider use of guidelines for prescribing opioids for pain (specify) o Bree o CDC o AMDG o Other (specify)	Select if appropriate
• Key clinical decision support features for opioid prescribing guidelines (specify)	Select if appropriate
• Linkage to behavioral health care and MAT for people with opioid use disorders (specify pathway)	Select if appropriate
• Offer take home naloxone -Hospitals report ED site	Select if appropriate
• Provides or refers to an access point in which persons can be referred to MAT	Select if appropriate
• Refers or provides services aimed at reducing transmission of infectious diseases to persons who use injection drugs	Select if appropriate
• Other (specify)	Select if appropriate

3. How does your practice engage pharmacists as part of the care team?

• Direct Hire	Select if appropriate
• System resource	Select if appropriate
• Contract	Select if appropriate
• In planning	Select if appropriate
• Other agreement (specify)	Select if appropriate

• Other (specify)	Select if appropriate

4. How many hours per week is the pharmacist engaged for coordination of care of medication management?

Enter narrative

5. How does the pharmacist(s) on your team engage in patient care? Select all that apply:

• Pre-appointment review and planning without patient present	Select if appropriate
• Pre-appointment consultation and planning with patient	Select if appropriate
• Coincident referral ("warm hand-off") for consultation	Select if appropriate
• Follow-up referral from provider for appointment	Select if appropriate
• Medication review and recommendations in the EHR (asynchronous with visit)	Select if appropriate
• Specified medication management appointment or clinic (e.g., warfarin management or lipid management)	Select if appropriate
• E-consultations with patients through patient portal or other asynchronous communication	Select if appropriate
• Home visit	Select if appropriate
• As part of a group visit	Select if appropriate
• Other (specify)	Select if appropriate

6. How are patients selected for medication management services beyond routine medication reconciliation? These indications may be overlapping. Select all that apply:

• Based on risk cohorts (indicate which cohorts)	Select if appropriate

• Patients who have not achieved a therapeutic goal for a chronic condition (indicate the eligible conditions)	Select if appropriate
• Patients with care transitions (indicate which transitions or any qualifying factors)	Select if appropriate
• Patients with multiple ED visits or hospitalizations	Select if appropriate
• High-risk medications	Select if appropriate
• Complex medication regimens	Select if appropriate
• Other (specify)	Select if appropriate

7. Does your practice provide Collaborative Drug Therapy Management?

If yes, for what conditions? o Diabetes o Hypertension o Hyperlipidemia o Anticoagulation o Other	Select if appropriate
If no, indicate the reason for not providing this service by selecting one of the following: o In planning o Intend to do this but have not started yet o Not supported by State Scope of Practice o This is not a change we feel will significantly impact outcomes or care for our patients o Other (indicate)	Select if appropriate

8. Does your practice target care transitions for comprehensive medication management services?

If yes, what triggers these services? Check all that apply. o ED visit o Hospital admission	Select if appropriate

o Hospital discharge o NF or SNF admission o NF or SNF discharge o Referral Who receives these services? o All patients o Patients with specific risk factors (specify) o Other	
If no, indicate the reason for not providing this service by selecting one of the following: o In planning o Intend to do this but have not started yet o We address medication review, management, and coordination in this high-risk period in a different way (specify how)	Select if appropriate

9. What process measures does your practice use to improve medication effectiveness and safety?

Enter Narrative

MILESTONE 3

Milestone	Milestone Category	Reporting Quarter	Reporting Method
3A.1	24/7 Access by Patients & Enhanced Access	Q1-4	X, #, N

Milestone 3 Reporting: 24/7 Access by Patients & Enhanced Access

3A.1 24/7 Access by Patients & Enhanced Access [Quarterly] [X, #, N]

1. Please confirm that your practice's patients continue to have 24 hour/7 days a week access to a care team practitioner who has real-time access to their EHR.

Yes, patients have 24 hour/7 days a week access to a care team practitioner who has real-time access to its EHR	Select if appropriate
If no, when does your practice expect to have 24/7 access to your EHR for all practitioners covering calls after patient hours? • Within 3 months • Between 3 and 6 months • More than 6 months	Select if appropriate

2. Please tell us how your practice is providing enhanced patient access. (Care provided to patients outside of office visits) Select all that apply:

• Patient portal messages	Select if appropriate
• Email	Select if appropriate
• Text messaging	Select if appropriate
• Structured phone visits	Select if appropriate
• In progress/we are currently building this capacity	Select if appropriate
• Other (specify)	Select if appropriate

3. To enhance reimbursements from the Managed Care Organizations, it benefits the practice to track hours of care provided outside of the office. **On average, about how many hours per week does staff spend on care provided to the patient outside of office visits?** Please complete the following table. Enter "0" if your practice does not have the specific staff category. Estimate the total hours per week for each quarter. Use whole numbers only with no decimals.

Staff Time Spent on Care Provided Outside of Visits					
Category	**Number of Staff in Category**	**Estimated Hours per Week in Quarter 1**	**Estimated Hours per Week in Quarter 2**	**Estimated Hours per Week in Quarter 3**	**Estimated Hours per Week in Quarter 4**
Physician	# staff	#hours/week	#hours/week	#hours/week	#hours/week
PA	# staff	#hours/week	#hours/week	#hours/week	#hours/week
APRN/NP	# staff	#hours/week	#hours/week	#hours/week	#hours/week
RN	# staff	#hours/week	#hours/week	#hours/week	#hours/week
LPN	# staff	#hours/week	#hours/week	#hours/week	#hours/week
MA	# staff	#hours/week	#hours/week	#hours/week	#hours/week
Health Educator	# staff	#hours/week	#hours/week	#hours/week	#hours/week
Behavioral Health Professional	# staff	#hours/week	#hours/week	#hours/week	#hours/week
Administrative	# staff	#hours/week	#hours/week	#hours/week	#hours/week
Pharmacist	# staff	#hours/week	#hours/week	#hours/week	#hours/week
Other (specify)	# staff	#hours/week	#hours/week	#hours/week	#hours/week
Other (specify)	# staff	#hours/week	#hours/week	#hours/week	#hours/week

4. Enhanced access or care provided outside of normal office hours is a new concept for patients and their families. This new concept needs to be communicated to patients. **How does your practice indicate information about enhanced access to patients and families?**

   Select all that apply:

• Poster in office	Select if appropriate

• Hand-out given to patient in office	Select if appropriate
• Website	Select if appropriate
• Mailing to patients	Select if appropriate
• Verbally from staff	Select if appropriate
• Other (Specify)	Select if appropriate

MILESTONE 4

Milestone	Milestone Category	Reporting Quarter	Reporting Method
4A.1	Patient Experience - Patient-Centered Interactions	Q1-4	X, #, N
4A.2	Patient Experience - Shared Decision Making	Q1-4	#, N

Milestone 4 Reporting: Patient Centered Interactions

4A.1 Patient Experience – Patient-Centered Interactions [Quarterly] [X, #, N]

1. In Quarter 1, your practice will select the assessment method(s) that will be used (please note: this selection cannot be changed in subsequent quarters):

• **Option A**: Conduct a monthly practice-based survey of their patients,	Select if appropriate
• **Option B**: Create and conduct a PFAC quarterly	Select if appropriate
• **Option C**: Conduct a practice-based survey and conduct a PFAC on a semi-annual basis	Select if appropriate

2. If you conducted the monthly or semi-annual practice-based survey (Option A or Option C), please report:

• How is the survey being conducted?	Enter narrative
• What population is receiving the survey?	Enter narrative
• How many surveys were sent out and how many of those were returned?	Enter narrative

3. If you conducted the quarterly or semi-annual PFAC (Option B or Option C), please report:

• How many people attended the PFAC and identify roles: patient, family member, practitioner or other	Enter narrative

4. For both the practice-based survey and the PFAC, please report:

• Please provide a narrative of what QI efforts will be implemented as a result of the PFAC and/or practice-based survey.	Enter narrative

4A.2 Patient Experience – Shared Decision Making [Quarterly] [#, N]

1. Identify at least TWO health conditions, decisions, or tests of focus for which your practice is implementing shared decision making. Select two to five options.

   The following list contains some common preference-sensitive conditions for your practice to consider. Ideally, your practice is focusing on an area that is important to the patients in your practice and for which you can acquire an aid/tool

• Management of acute low back pain (with red flags)	Select if appropriate
• Antibiotic overuse for upper respiratory infection	Select if appropriate
• Management of anxiety or depression	Select if appropriate
• Management of asthma	Select if appropriate
• Management of chronic back pain	Select if appropriate
• Management of chronic pain	Select if appropriate
• Management of congestive heart failure	Select if appropriate
• Management of COPD	Select if appropriate
• Medications in diabetes	Select if appropriate
• Electrocardiogram and cardiac stress testing	Select if appropriate
• Care preferences over the life continuum	Select if appropriate
• Colon cancer screening	Select if appropriate
• Management of heart failure	Select if appropriate

• Management of coronary heart disease	Select if appropriate
• Management of Peripheral Artery Disease	Select if appropriate
• Managing health concerns of older adults	Select if appropriate
• Chronic, Stable Angina	Select if appropriate
• Management of Trigger Finger	Select if appropriate
• Lung cancer screening in smokers	Select if appropriate
• Management of tobacco cessation	Select if appropriate
• Management of Obesity	Select if appropriate
• Other (specify)	Select if appropriate

2. For the priority area(s) selected above, please identify the producers of the decision aids that your practice will use:

• Agency for Health Care Research Quality (AHRQ) and Health Dialog/Informed Medical Decision	Select if appropriate
• Center for Disease Control (CDC)	Select if appropriate
• Healthwise Decision Points	Select if appropriate
• Emmi Solution	Select if appropriate
• Mayo Clinic	Select if appropriate
• Food and Drug Administration (FDA)	Select if appropriate
• Other (specify)	Select if appropriate

3. For each area of priority selected, indicate the counts or rate (percentage) of eligible patients who received a decision aid for the selected area of focus. This rate should increase over time as your practice works to implement this decision aid.

   Please select your preference for reporting, either reporting as a count or reporting as a rate:

- For practices who chose to report as a count: For each area of focus, report number of eligible patients who received a decision aid
- For practices who chose to report as a rate: For each area of focus: report percent of eligible patients who received the decision aid:

Health conditions, decisions, or tests of focus:	Report as a count	Report as a rate
Focus area	Number of eligible patients	Percentage of eligible patients
Focus area	Number of eligible patients	Percentage of eligible patients
Focus area	Number of eligible patients	Percentage of eligible patients
Focus area	Number of eligible patients	Percentage of eligible patients
Focus area	Number of eligible patients	Percentage of eligible patients

MILESTONE 5

Milestone	Milestone Category	Reporting Quarter	Reporting Method
5A.1	Quality Improvement Team Engaged Leadership, Quality Improvement Strategy	Q1-4	N
5A.2	Clinical Quality Metrics	Q1-4	X, #
5A.3	Practice Transformation Implementation Work Plan	Q1-4	X

Milestone 5 Reporting: Quality Improvement

5A.1 Quality Improvement Team Engaged Leadership, Quality Improvement Strategy [Quarterly] [X]

1. The organization will attest to operating an internal QI Team that includes organizational clinicians, IT, senior leadership, finance, etc. that meets no less frequently than monthly.

Attest Yes: The organization operates an internal QI Team	**Attest No**: The organization does not operate an internal QI Team
Select if appropriate	Select if appropriate

5A.2 Clinical Quality Metrics [Quarterly] [X, #, N]

1. For this milestone, your practice is required to provide practitioner or care team reports on at least three measures at least quarterly to support improvement in care. **In this past quarter, for which quality measures did your practitioner(s) or care team(s) focus their quality improvement activities?** Select all that apply:

• Antidepressant Medication Management: o Acute Phase of Treatment o Continuation Phase of Treatment	Select if appropriate
• Child and Adolescents' Access to PCPs: o 12-23 Months o 2-6 Years o 7-11 Years o 12-19 Years	Select if appropriate
• Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	Select if appropriate
• Comprehensive Diabetes Care: Hemoglobin A1c Testing	Select if appropriate

• Comprehensive Diabetes Care: Medical Attention for Nephropathy	Select if appropriate
• Depression Screening and Follow-up for Adolescents and Adults	Select if appropriate
• Follow-up After Discharge from ED for Alcohol or Other Drug Dependence: o 7 Days o 30 Days	Select if appropriate
• Follow-up After Discharge from ED for Mental Health: o 7 Days o 30 Days	Select if appropriate
• Follow-up After Hospitalization for Mental Illness: o 7 Days o 30 Days	Select if appropriate
• Inpatient Hospital Utilization (includes psychiatric)	Select if appropriate
• Medication Management for People with Asthma (5 – 64 Years)	Select if appropriate
• Mental Health Treatment Penetration (Broad Version)	Select if appropriate
• Outpatient Emergency Department Visits per 1,000 Member Months: o 0-17 years o 18+ years	Select if appropriate
• Patients on High-Dose Chronic Opioid Therapy by Varying Thresholds	Select if appropriate
• Patients with Concurrent Sedatives Prescriptions	Select if appropriate
• Percent Homeless (Narrow Definition)	Select if appropriate
• Plan All-Cause Readmission Rate (30 Days)	Select if appropriate

• Statin Therapy for Patients with Cardiovascular Disease (Prescribed)	Select if appropriate
• Substance Use Disorder Treatment Penetration	Select if appropriate
• To be determined	

Please provide practitioner or care team reports to your Practice Transformation Navigator

2. Your practice should review all CQMs for your entire practice site on a regular basis. Identify how often your practice is reviewing all CPC CQMs for the practice site.

• Weekly	Select if appropriate
• Monthly	Select if appropriate
• Quarterly	Select if appropriate
• Our EHR cannot support practice site level reports.	Select if appropriate

3. Identify who in your practice does the work of making data from the EHR available to guide and inform efforts to improve care and utilization, either on a systematic basis (provider or practice quality or utilization reports) or to answer a specific question that might arise (e.g., "Who are my patients with an A1C greater than 9?").

• Dedicated data analyst(s)	Select if appropriate
• Medical records staff	Select if appropriate
• Clinic Manager	Select if appropriate
• Physician	Select if appropriate
• PA	Select if appropriate
• APRN/NP	Select if appropriate
• RN	Select if appropriate
• LPN	Select if appropriate

• MA	Select if appropriate
• Other Care Manager	Select if appropriate
• Other (specify)	Select if appropriate

4. Your practice should regularly create individual practitioner or care team CQM reports. Identify how often your practice's individual practitioners and/or care teams review panel-specific CQM data.

• Weekly	Select if appropriate
• Monthly	Select if appropriate
• Quarterly	Select if appropriate
• Our practice cannot create panel-specific CQM reports	Select if appropriate

5A.3 Practice Transformation Implementation Work Plan [Quarterly]

1. Actively engage with your Practice Transformation Navigator to implement and update the PTIW document throughout the demonstration.

Attest Yes: The organization actively engages with its Practice Transformation Navigator	**Attest No**: The organization does not engage with its Practice Transformation Navigator
Select if appropriate	Select if appropriate

MILESTONE 6

Milestone	Milestone Category	Reporting Quarter	Reporting Method
6A.1	Care Coordination Across the Medical Neighborhood	Q1-4	X, #, N

Milestone 6 Reporting: Care Coordination

6A.1 Care Coordination Across the Medical Neighborhood [Quarterly] [X, #, N]

1. Please attest that your practice is using at least one of the following tools: EDIE, PreManage and/or Direct Secure Messaging.

Attest Yes: The organization is using at least one HIT tool listed above	**Attest No**: The organization is not using any HIT tool listed above
Select if appropriate	Select if appropriate

2. Building on your practice's PY 2018/2019 activities, select two of the following care coordination options. Further detail on the requirements of each option is below. Please note: The selection made in Quarter 1 cannot be changed in subsequent quarters.

• **Option A**: Track the percent (%) of patients with ED visits who received follow-up contact within one week of discharge	Select if appropriate
• **Option B**: Contact at least 75% of patients who were hospitalized in target hospital(s) within 72 hours of discharge	Select if appropriate
• **Option C**: Enact care compacts/collaborative agreements with at least two groups of high-volume specialists in different specialties to improve coordination and transitions of care	Select if appropriate

Option A: Follow-up contact with patient within one week of ED discharge.

Targeted Emergency Department: EDs receiving high-volumes of your organization's empaneled patients

Numerator: Number of your patients that received a follow-up contact within one week after ED discharge

Denominator: Number of your patients discharged from the target ED during this quarter

Targeted ED	Numerator	Denominator
Emergency Department	#	#
Emergency Department	#	#
Emergency Department	#	#
Emergency Department	#	#

On a quarterly basis, identify the methods that your practice uses for obtaining ED discharge information. Select all that apply:

• Phone	Select if appropriate
• Fax	Select if appropriate
• Email	Select if appropriate
• Health Information Exchange	Select if appropriate
• Collective Medical Platform (e.g., Emergency Department Information Exchange, (EDIE), PreManage)	Select if appropriate
• Other	Select if appropriate

Option B: Conduct follow-up contact within 72 hours of hospital discharge.

The Medicaid Transformation Program goal for care coordination across the medical neighborhood is that your practice contacts **at least 75% of patients within 72 hours of discharge from one or more target hospital(s)**. A target hospital is defined as a facility from which your practice can receive regular and timely information about your patient population's hospitalizations.

Identify the hospital(s) of focus and the counts for tracking your practice's follow-up contact with discharged patients. Estimate these counts, if necessary.

Numerator: Number of your patients who received follow-up contact within 72 hours after discharge

Denominator: Number of your patients discharged from the target hospital during this quarter

Name of Hospital	Numerator	Denominator
Hospital	#	#
Hospital	#	#

Hospital	#	#

On a quarterly basis, identify the methods that your practice uses for obtaining hospital discharge information. Select all that apply:

• Phone	Select if appropriate
• Health Information Exchange	Select if appropriate
• Email	Select if appropriate
• Fax	Select if appropriate
• Collective Medical Platform (e.g., Emergency Department Information Exchange, (EDIE), PreManage)	Select if appropriate
• Other	Select if appropriate

Option C: Enter care compacts/agreements with at least two high-referral community partners and/or natural community partners.

Your practice will enact Care Compact and Agreements with at least two groups of high-referral Community Partners and/or Natural Community Partners in different specialties to improve the coordination and transitions of care for your patient population. Identify the Community Partners and/or Natural Community Partners types with whom you have arranged these care compacts/ collaborative agreements. Select all that apply and select at least two from the following options:

- Allergy
- Behavioral Health
- Cardiology
- Dermatology
- Endocrinology
- Gastroenterology
- Health Homes
- Hematology
- Infectious Disease
- Nephrology
- Neurology
- Obstetrics/Gynecology
- Oncology
- Ophthalmology
- Orthopedic Surgery
- Pain Management
- Podiatry
- Pulmonology
- Psychiatry
- Urology
- Radiology & Imaging
- Rheumatology
- SNFs
- Social Services
- SUD Providers
- Other

Community Partners	Specialty
Community Partners	Specialty

Community Partners	Specialty
Community Partners	Specialty
Community Partners	Specialty
Community Partners	Specialty

Note**:** Please retain a copy of the signed care compacts/collaborative agreements that your practice has with the high-referral Community Partners and/or Natural Community Partners in your community.

MILESTONE 7

Milestone	Milestone Category	Reporting Quarter	Reporting Method
7A.1	Participation in the Learning Collaborative	Q4	X, N

Milestone 7 Reporting: Participation in Learning Collaboratives

7A.1 Participation in the Learning Collaborative [Quarter 4] [X, N]

Milestone 7 captures the work involved in participation in both your region's state and national learning collaboratives; each practice has a responsibility to actively engage and share in the learning with other practices, regionally and nationally. For each activity in the following list, practices will attest to whether your practice met the requirements for participation. If your practice was not able to complete one or more of the activities, please indicate the reason.

1. Participated in at least one learning session in your region per month.

• Community Our Practice Site participated in the above activities during PY 2018/2019Partners	Select if appropriate
• Our Practice Site DID NOT participate in the above activities during PY 2018/2019 – provide explanation Community Partners	Select if appropriate

Or

Participated in at least one learning webinar per month.

• Our Practice Site participated in the above activities during PY 2018/2019.	Select if appropriate
• Our Practice Site DID NOT participate in the above activities during PY 2018/2019 – provide explanation	Select if appropriate

2. Contribute a minimum of one document of experiential story spotlighting success over the year.

• Our Practice Site participated in the above activities during Program Year 2018/2019	Select if appropriate
• Our Practice Site DID NOT participate in the above activities during Program Year 2018/2019 - provide explanation.	Select if appropriate

3. Fully engage with the GCACH Practice Transformation Team, including by providing regular status information as requested, for the purposes of monitoring progress toward milestone completion and/or for the purposes of providing support to meet the milestones.

• Our Practice Site participated in the above activities during Program Year 2018/2019.	Select if appropriate
• Our Practice Site DID NOT participate in the above activities during Program Year 2018/2019 - provide explanation.	Select if appropriate

4. Please attest that member(s) of your QI and/or clinical teams participated in at least four Leadership Council meetings. Attest that at least one provider attends at least four learning collaboratives provided by GCACH. Please provide names and titles of those individuals attending the above.

Attest Yes: Organizational staff have attended at least four Leadership Council meetings	**Attest No**: Organizational staff have not attended at least four Leadership Council meetings
Select if appropriate	Select if appropriate

Please list staff attending these meetings:

Staff person name	Staff person title
Staff person name	Staff person title
Staff person name	Staff person title
Staff person name	Staff person title

Attest Yes: Organizational staff have attended at least four learning collaborative sessions	**Attest No**: Organizational staff have not attended at least four learning collaborative sessions s
Select if appropriate	Select if appropriate

Please list staff attending these meetings:

Staff person name	Staff person title
Staff person name	Staff person title
Staff person name	Staff person title
Staff person name	Staff person title

MILESTONE 8

Milestone	Milestone Category	Reporting Quarter	Reporting Method
8A.1	Health Information Technology	Q1	N

Milestone 8 Reporting: Health Information Technology

8A.1 Health Information Technology (PCMH/MeHAF Assessments) [Quarter 1] [X]

1. In the first quarter, your practice will indicate that you are using an ONC-certified EHR. In subsequent quarters, your practice will have ability to exchange health information and attest that all eligible professionals have successfully identified the settings in which you are able to exchange electronic patient information securely to other entities (i.e., direct secure messaging, patient portal, etc.).

Attest Yes: Yes, we are using an ONC-certified EHR	**Attest No**: No, we are not using an ONC-certified EHR
Select if appropriate	Select if appropriate

2. The ability to exchange electronic health information is emerging in many and offers your practice a powerful tool for providing comprehensive primary care while improving care and health outcomes at lower cost. Please indicate with which settings you are able to securely exchange patient information. Select all that apply:

• Acute care hospital/ED	Select if appropriate
• Urgent care center	Select if appropriate
• Rehabilitation hospital	Select if appropriate
• Specialty hospital	Select if appropriate
• Skilled nursing facility	Select if appropriate
• Social service agency	Select if appropriate
• Other long-term care facility	Select if appropriate
• Ambulatory surgery center	Select if appropriate

• Other health clinics/physician offices	Select if appropriate
• Home health/hospice	Select if appropriate
• Public health department	Select if appropriate
• Pharmacy	Select if appropriate
• Other	Select if appropriate

3. Please attest that the organization has met with the Practice Transformation Navigator to discuss and identify infrastructure and resources required during the Medicaid Transformation Project period:

Attest Yes: We have met with the Practice Transformation Navigator to discuss infrastructure and resource needs.	**Attest No**: We have not met with the Practice Transformation Navigator to discuss infrastructure and resource needs.
Select if appropriate	Select if appropriate

Instructions: Please provide names and emails for individuals who have been actively involved in across separate tabs, or in a single tab that indicates which group/committee the person belongs Michelle.A.Chapdelaine@kp.org. Thanks!

Governing Boa

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your ACH's work/activities over the last year. Feel free to organize this
to. If you have any questions, please contact

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Organizational Self-Assessment of Internal Controls and Risks

ACH Name: Greater Columbia Accountable Community of Health

Date Prepared: October 29, 2018

Answer "Yes" if the activity in question is performed internally or externally (unless specified). Each "No" answer indicates a potential weakness of internal fiscal controls. All "No" answers require an explanation of mitigating controls or a note of planned changes. If the activity does not apply to your organization, answer N/A.

I. CONTROL ENVIRONMENT

A. Management's Philosophy and Operating Style

Yes	N/A	No	
☒	☐	☐	1. Are periodic (monthly, quarterly) reports on the status of actual to budgeted expenditures prepared and reviewed by top management?
☒	☐	☐	2. Are unusual variances between budgeted revenues and expenditures and actual revenues and expenditures examined?
☒	☐	☐	3. Is the internal control structure supervised and reviewed by management to determine if it is operating as intended?

B. Organizational Structure

☒	☐	☐	4. Is there a current organizational chart defining the lines of responsibility?
☒	☐	☐	5. Have all staff been sufficiently trained to perform their assigned duties?

C. Assignment of Authority and Responsibility

☒	☐	☐	6. Are sufficient training opportunities to improve competency and update employees on Program, Fiscal and Personnel policies and procedures available?
☒	☐	☐	7. Have managers been provided with clear goals and direction from the governing body or top management?
☒	☐	☐	8. Is program information issued by the Health Care Authority distributed to appropriate staff?

II. HUMAN RESOURCES

A. Control Activities/Information and Communication

Yes	N/A	No	
☒	☐	☐	1. Are personnel policies in writing?
☒	☐	☐	2. Are personnel files maintained for all employees?

II. HUMAN RESOURCES *(continued)*

A. Control Activities/Information and Communication

Yes	N/A	No	
☒	☐	☐	3. Are payroll costs accurately charged to grants using time spent in each program?
☒	☐	☐	4. Are accurate, up-to-date position descriptions available?
☒	☐	☐	5. Do all supervisors and managers have at least a working knowledge of personnel policies and procedures?
☒	☐	☐	6. Does each supervisor and manager have a copy or access to a copy of personnel policies and procedures?
☒	☐	☐	7. Does management ensure compliance with the organization's personnel policies and procedures manual concerning hiring, training, promoting, and compensating employees?
			8. Are the following duties generally performed by different people?
☐	☐	☒	a. Processing personnel action forms and processing payroll?
☐	☐	☒	b. Supervising and timekeeping, payroll processing, disbursing, and making general ledger entries?
☐	☐	☒	c. Personnel and approving time reports?
☐	☐	☒	d. Personnel and payroll preparation?
☐	☐	☒	e. Recording the payroll in the general ledger and the payroll processing function?
☒	☐	☐	9. Is access to payroll/personnel files limited to authorized individuals?
☒	☐	☐	10. Are procedures in place to ensure that all keys, equipment, credit cards, cell phones, laptops, etc. are returned by the terminating employee?
☒	☐	☐	11. Is information on employment applications verified and are references contacted?

III. ACCOUNTS PAYABLE

A. Control Activities/Information and Communication

Yes	N/A	No	
☒	☐	☐	1. Has the organization established procedures to ensure that all voided checks are properly accounted for and effectively cancelled?

III.ACCOUNTS PAYABLE (continued)
A. Control Activities/Information and Communication

Yes	N/A	No	
			2. Do invoice-processing procedures provide for:
☒	☐	☐	a. Obtaining copies of requisitions, purchase orders and receiving reports?
☒	☐	☐	b. Comparison of invoice quantities, prices, and terms with those indicated on the purchase order?
☒	☐	☐	c. Comparison of invoice quantities with those indicated on the receiving reports?
☒	☐	☐	d. As appropriate, checking accuracy of calculations?
☒	☐	☐	e. Alteration/destruction of extra copies of invoices to prevent duplicate payments?
☒	☐	☐	f. All file copies of invoices are stamped/marked paid to prevent duplicate payments?
☒	☐	☐	3. Are payments made only on the basis of original invoices and to suppliers identified on supporting documentation?
☒	☐	☐	4. Are the accounting and purchasing departments promptly notified of returned purchases and are such purchases correlated with vendor credit memos?
			5. Are monthly reconciliations performed on the following:
☐	☒	☐	a. All petty cash accounts?
☒	☐	☐	b. All bank accounts?
			6. Are the following duties generally performed by different people?
☐	☐	☒	a. Requisitioning, purchasing, and receiving functions and the invoice processing, accounts payable, and general ledger functions?
☐	☐	☒	b. Purchasing, requisitioning, and receiving?
☐	☐	☒	c. Invoice processing and making entries to the general ledger?
☐	☒	☐	d. Preparation of cash disbursements, approval of them, and making entries to the general ledger?
☒	☐	☐	7. Is check signing limited to only authorized personnel?
☒	☐	☐	8. Are disbursements approved for payment only by properly designated officials?

III.ACCOUNTS PAYABLE (continued)
A. Control Activities/Information and Communication

Yes	N/A	No	
☒	☐	☐	9. Is the individual responsible for approval or check signing furnished with invoices and supporting data to be reviewed prior to approval or check-signing?
☒	☐	☐	10. Are unused checks adequately controlled and safeguarded?
☒	☐	☐	11. Is it prohibited to sign blank checks in advance?
☒	☐	☐	12. Is it prohibited to make checks out to the order of "cash"?
☐	☒	☐	13. If facsimile or e-signatures are used, are the signature plates adequately controlled and separated physically from blank checks?
☒	☐	☐	14. Are purchase orders pre-numbered and issued in sequence?
☒	☐	☐	15. Are changes to contracts or purchase orders subject to the same controls and approvals as the original agreement?
☒	☐	☐	16. Are all records, checks and supporting documents retained according to the applicable record retention policy?

IV. COMPLIANCE SUPPLEMENT ELEMENTS
A. Cash Management
Control Activities/Information and Communication

Yes	N/A	No	
☒	☐	☐	1. Are requests for advance payment (A-19's) based on actual program needs?
			2. Are the following duties generally performed by different people?
☒	☐	☐	a. Preparing the request for payment from HCA (A-19)?
☒	☐	☐	b. Reviewing and approving the request for advance payment from HCA (A-19)?

B. Equipment and Real Property Management
Control Activities/Information and Communication

Yes	N/A	No	
☒	☐	☐	4. Are all disposals of property approved by a designated person with proper authority?
☒	☐	☐	5. Has organization management chosen and documented the threshold level for capitalization in an internal policy/procedure book?

IV.COMPLIANCE SUPPLEMENT ELEMENTS *(continued)*
B. Equipment and Real Property Management
Control Activities/Information and Communication

Yes	N/A	No	
☒	☐	☐	6. Is someone assigned custodial responsibility by location for all assets?
☒	☐	☐	7. Is access to the perpetual fixed asset records limited to authorized individuals?
☒	☐	☐	8. Is there adequate physical security surrounding the fixed asset items?
☒	☐	☐	9. Is there adequate insurance coverage of the fixed asset items?
☒	☐	☐	10. Is insurance coverage independently reviewed periodically?
☒	☐	☐	11. Is a fixed asset inventory taken annually?
☒	☐	☐	12. Are missing items investigated and reasons for them documented?

C. Procurement and Suspension and Debarment

Non-Federal entities are prohibited from contracting with or making sub awards under covered transactions to parties that are suspended or debarred or whose principals are suspended or debarred. Covered transactions include procurement contracts for goods or services equal to or in excess of $100,000 and all non-procurement transactions. Http://www.sam.gov/ This website is provided by the General Services Administration (GSA) for the purpose of disseminating information on parties that are excluded from receiving Federal contracts, certain subcontracts, and certain Federal financial and nonfinancial assistance and benefits.

Control Activities/Information and Communication

Yes	N/A	No	
☒	☐	☐	1. Is there established segregation of duties between employees responsible for contracting; accounts payable and cash disbursing.
☒	☐	☐	2. Is the contractor's performance included in the terms, conditions, and specifications of the contract monitored and documented?
☒	☐	☐	3. Do supervisors review procurement and contracting decisions for compliance with Federal procurement policies?
☒	☐	☐	4. Are procedures established to verify that vendors providing goods and services under the award have not been suspended or debarred by the Federal government?

C. Procurement and Suspension and Debarment
Control Activities/Information and Communication

Yes	N/A	No	
			5. Are there written policies for the procurement and contracts establishing:
☒	☐	☐	a. Contract files
☒	☐	☐	b. Methods of procurement
☒	☐	☐	c. Contractor rejection or selection
☒	☐	☐	d. Basis of contract price
☒	☐	☐	e. Verification of full and open competition
☒	☐	☐	f. Requirements for cost or price analysis
☒	☐	☐	g. Obtaining and reacting to suspension and debarment certifications
☒	☐	☐	h. Other applicable requirements for Federal procurement
☒	☐	☐	i. Conflict of interest
☒	☐	☐	6. Is there written policy addressing suspension and debarments of contractors?
☒	☐	☐	7. Are there proper channels for communicating suspected procurement and contracting improprieties?
☒	☐	☐	8. Does management perform periodic review of procurement and contracting activities to determine whether policies and procedures are being followed?

D. Reporting
Control Activities/Information and Communication

Yes	N/A	No	
☒	☐	☐	1. Are personnel responsible for submitting required reporting information adequately trained?
☒	☐	☐	2. Does management review required reports before submitting?

E. Single Audit
Control Activities/Information and Communication

Yes	N/A	No	
☒	☐	☐	1. Was the organization audited by an objective accounting firm this past fiscal year?
☒	☐	☐	2. Did appropriate organization staff review the findings of the previous years' audit as preparation for the current year audit?

E. Single Audit *(continued)*
Control Activities/Information and Communication

Yes	N/A	No	
☒	☐	☐	3. Have all audit findings and questioned costs from previous years been appropriately resolved?

V. CERTIFICATION

I hereby certify that the information presented in this self-assessment of internal controls and risk is true, accurate, and complete, to the best of my knowledge.

Greater Columbia Accountable Community of Health
Organization Name

Carol Moser

1/31/19

Authorized Official Signature ***Date***

NOTES:

II. HUMAN RESOURCES *(continued)*
A. Control Activities/Information and Communication

8 (a-e): Due to the small organization it is difficult to have different people for each processing entity. To counteract this the Director of Finance & Contracts reviews all transactions listed in 8a-e, as does the Executive Director. The Executive Director reviews and signs at the bottom of monthly transaction reports or personnel changes certifying reviewal and approval.

II. ACCOUNTS PAYABLE
A. Control Activities/Information and Communication

6 (a-c): As mentioned above, due to our organization size, it is common for multiple financial roles to fall onto the Director of Finance & Contracts / Financial Support. Between both positions the jobs mentioned in 6 a-c are completed. To limit risk, the Executive Director reviews and signs monthly reports for all purchases and disbursements that are made.