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:

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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 benefit and patient safety at lowest cost	Select if appropriate
• 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	Select if appropriate

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.	
• **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. ○ 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 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	Select if appropriate
• **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	Select if appropriate

○ 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	
• **Option C:** 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	Select if appropriate

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? ○ Diabetes ○ Hypertension ○ Hyperlipidemia ○ Anticoagulation	Select if appropriate

○ 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)	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. ○ 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	Select if appropriate
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)	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: ○ Acute Phase of Treatment ○ Continuation Phase of Treatment	Select if appropriate
• Child and Adolescents' Access to PCPs: ○ 12-23 Months ○ 2-6 Years ○ 7-11 Years ○ 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: ○ 7 Days ○ 30 Days	Select if appropriate
• Follow-up After Discharge from ED for Mental Health: ○ 7 Days ○ 30 Days	Select if appropriate
• Follow-up After Hospitalization for Mental Illness: ○ 7 Days ○ 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: ○ 0-17 years ○ 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