GREATER COLUMBIA
ACCOUNTABLE COMMUNITY OF HEALTH

GREATER COLUMBIA CARES MODEL IMPLEMENTATION & REPORTING TOOLKIT

GREATER COLUMBIA ACCOUNTABLE COMMUNITY OF HEALTH
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Welcome to the Medicaid Transformation! This is your 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. The Greater Columbia Cares Model Implementation & Reporting Toolkit (Toolkit) outlines each milestone by intent, work, and reporting requirements you will need to complete 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 (MT) 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 (ACH) 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 and watch your journey and growth in the coming year. Your Practice Transformation Navigator will orient you to the CSI portal, the reporting platform where your organization will upload your quarterly performance across all of the milestone deliverables outlined in the Toolkit. 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. **The mandatory reporting due date is the 15th of the month following the quarter's end. The Director of Practice Transformation will review all submissions within 30 days. Any deficiencies will be documented in your Practice Transformation Implementation Workplan (PTIW) located in the CSI portal, as well as communicated via email by your Practice Transformation Navigator. There will be a 6-day grace period to correct any deficiencies from the time of communication.**

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 1, 2 and 3
Greater Columbia Cares Model (GCCM) Implementation & Reporting Toolkit

Patient-Centered Medical Home (PCMH) 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 a practice transformation team that provides hands-on support for your journey.

The Safety Net Medical Home Initiative (SNMHI), led in partnership by Qualis and the MacColl Institutes for Healthcare Innovation developed a framework for PCMH transformation, the "Change Concepts" for practice transformation that GCACH uses 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 hands-off patient care.

Each SNMHI Change Concept includes "key changes." 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 (http://www.safetynetmedicalhome.org/) provides access to implementation guides, assessment tools, presentations, and other materials on the Change Concepts, and payment and recognition resources.

The Patient Centered Medical Home Assessment (PCMH-A) and the Maine Health Access Foundation (MeHAF) 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.

The initial practice transformation model has evolved to the Greater Columbia Cares Model (GCCM). The initial practice transformation model was more focused on the foundational PCMH concepts. The GCCM model adds other evidence-based initiatives including the Chronic Care Model, 6 Building Blocks, Comprehensive Primary Care Initiative, and population health concepts such as social determinants of health, health equity, and risk stratification.

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

GCACH 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 CSI portal. Greater Columbia supports practices in attaining the Medicaid Transformation 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 CSI portal. 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 in PY 1, 2 and 3. Medicaid Transformation (MT) 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 your Program Year (PY), your practice will report a proposed budget by uploading the budget document into the CSI portal. Milestone 1 includes reporting the practice site's final funding and costs using the PCMH Budget Template for PY 1, 2 and 3 (see Appendix A- PCMH Budget Template).

Please bear in mind all information entered into the CSI portal 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 1, 2 and 3 milestones. Using a structured process to plan your budget for PY 1, 2 and 3 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.

Milestone 1: Reporting

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

In each practice transformation year, your practice will provide an estimated budget. Please use the PCMH Budget Template for Year 1 or Year 2. If you have questions please contact your Practice Transformation Navigator.

Due Dates

Cohort 1, Year 2 – February 15, 2020

Cohort 1, Year 3 – February 15, 2021

Cohort 2, Year 2 – August 15, 2020

Cohort 2, Year 3 – August 15, 2021

Cohort 3, Year 1 – February 15, 2020

Cohort 3, Year 2 – February 15, 2021

Cohort 3, Year 3 – February 15, 2022

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

Your practice will report final funding and costs. Please use the PCMH Budget Template for Year 1 or Year 2. If you have questions please contact your Practice Transformation Navigator.

Due Dates

Cohort 1, Year 2 – January 15, 2021

Cohort 1, Year 3 – January 15, 2022

Cohort 2, Year 2 – July 15, 2021

Cohort 2, Year 3 – July 15, 2022

Cohort 3, Year 1 – January 15, 2021

Cohort 3, Year 2 – January 15, 2022

Cohort 3, Year 3 – January 15, 2023

This must be completed in the CSI portal. Please note: If the difference between the proposed budget was greater than 15% 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.

B. Submit a reconciled budget.

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 1, 2 & 3, 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. 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 PY 1. 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 (PTIW), and your practice will work toward maintaining at least 95% empanelment to provider(s) or care teams in PY 1, 2 & 3. 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 in PY 1. These percentages are expected to increase each PY. 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 1, 2 & 3 you will begin to risk stratify your patients and provide intensive care management for those at highest risk. In PY 1, 2 & 3 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 1, 2 & 3, we will ask you to identify which primary care strategies your practice will pursue this year in fourth quarter PY 1, 2 & 3. 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 PTIW. The PTIW will also be housed as a live document in the CSI portal.

Milestone 2 Reporting: Access and Continuity
Empanelment and Risk Stratification
2A.1 Empanelment Status [Quarterly] [#] Year 2: Mandatory

Your practice will work toward maintaining at least 95% empanelment to providers or care teams. 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.1B Empanelment Status [Quarterly] [#]

Please attest that you have reviewed your paneled patients against the rosters of the Managed Care Organizations (MCOs) on a monthly basis: Yes or No

Please provide the number of patients by MCO paneled in clinic and according to the MCO rosters

MCO	Number of Patients on MCO Roster	Number of Patients in the EHR
Amerigroup		
CHPW		
Coordinated Care		
Molina		

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.

Year 2: Of the 95% of empaneled patients identified in 2A.1, the target is to achieve risk stratification of at least 85% 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 95% 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 CSI portal 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.

   Year 2: Screening for Social Determinants of Health (SDOH) will be **mandatory**

• Social Determinants of Health (SDOH) **Mandatory for Year 2**	Select if appropriate
• 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	Select if appropriate

known criteria	
• 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. Year 2: Mandatory**

   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] [#] Mandatory – All 4 Quarters

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	
• Conducting a daily team-based huddle. **This is a mandatory activity for Year 2**	Select if appropriate
• 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	
• Conducting a daily team-based huddle. **This is a mandatory activity for Year 2**	Select if appropriate
• 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	
• Conducting a daily team-based huddle. **This is a mandatory activity for Year 2**	Select if appropriate
• 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 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 2B.1 Reporting: Bi-Directional Integration of Behavioral Health

2B.1 Bi-Directional Integration of Behavioral Health [Quarterly] [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
• Other (only for Cohort 2)	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. **Year 2:** Please indicate the percentage of people screened based on your selection(s) in Question 2.

Screening	Numerator	Denominator

4. 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

5. 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

6. 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

7. 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

8. 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

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

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

9. 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

10. 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

11. 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

12. 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

13. **Year 2 & 3**: Sites will follow-up with patients after 1 no show. Follow up can be completed via phone call or mailed letter. In the case of a phone call, there should be 3 attempts to contact the patient. Please indicate the number of patients that received a no-show and the number of patients that received follow up.

Number of No-Shows	Number of Follow-Ups

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. **Year 2 & 3:** Upload report showing integration of bi-directional care for narrative. **This is mandatory.**

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

    Year 2 & 3: MAT training, identification of a MAT referral, or Opioid Resource Network (ORN) is **mandatory.**

• Training -MAT Training	Select if appropriate
• MAT referral	Select if appropriate
• Opioid Resource Network	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

Milestone 2B.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:

• **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: ○ 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.	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. ○ 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	Select if appropriate

adapts and improves these strategies to improve care outcomes.	
• **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?

   Year 2: There is a minimum requirement of 10% of patients receiving self-management support

Condition	Provided by (staff or external resource)	Training or credentials	Number of patients that received the intervention
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-	Select if appropriate and specify team members

management	
• 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	
• Initiated process for referral to Health Home	Select if appropriate
• How's My Health	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. **Year 2 & 3:** Upload report showing the impact of self-management support based on the measures selected in Question 10. **This is mandatory.**

12. 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

Milestone 2B.3 Implementation Framework: Medication Management and Review

We have not set targets or timelines for this work in PY 1, 2 & 3 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 1, 2 & 3. 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 2B.3 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 2B.3 Reporting: Medication Management and Review
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: ○ Works on site ○ Is involved in patient care, either directly or through chart review and recommendations,	Select if appropriate

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	
• **Option B:** 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	Select if appropriate

○ 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 **(Mandatory for Year 2)**	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) ○ Bree ○ CDC ○ AMDG ○ 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?

   Year 2: Engaging pharmacists will be **mandatory**
   (i.e. collaborated, integrated, contractual, tele-pharmacy)

• 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?

   Year 2: Collaborative Drug Therapy Management is **mandatory** for contracted or staffed pharmacists.

If yes, for what conditions? ○ Diabetes ○ Hypertension ○ Hyperlipidemia ○ Anticoagulation ○ 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 ○ 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	Select if appropriate

○ 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?

Enter Narrative

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. With expectations to increase each PY.

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.

J. The practice has a systematic approach to reconcile all patients' medications and identify high-risk patients that would benefit from medication management.

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 1, 2 & 3, 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 1, 2 & 3, 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. In addition, in PY 2 & 3 your site will be required

to report on the third next available appoint type for: acute visits, adult well-checks, well-child checks and new patient visits.

The work in Milestone 3 addresses access to care beyond the office visit. In PY 1, 2 & 3, you ensured 24/7 access to care guided by the patient's information in the EHR. In PY 1, 2 & 3, 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 1, 2 & 3 requirements. **In PY 1, 2 & 3, 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 3A.1 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	Select if appropriate

• 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) 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. Please report the third next available appointment for the following appointment types: Acute visits, Adult well-visits, Well-Child Checks, and New Patient Visits

Appointment Type	Third Next Available Appointment
Acute Visits	
Adult well-visits	
Well-Child Checks	
New Patient Visits	

4. 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.
ACTION: Update categories (e.g. crisis)

5.

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

6. What workforce or training does your organization need in order to provide patient-centered care? (i.e., Community Health Worker, Behavioral Health Peer Specialist, ARNP, etc.)

Enter Narrative

7. 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 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. Please report the third next available appointment for the following appointment types: Acute visits, Adult well-visits, Well-Child Checks, and New Patient Visits

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

E. 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 health care. In PY 1, 2 & 3, 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 1, 2 & 3 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. Each quarter, the sites will be expected to show an increase in the percentage of patients that received surveys.

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 1, 2 & 3, you will test a decision aid as a way to engage patient in shared decision making. In PY 1, 2 & 3, 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 1, 2 & 3 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 (for more information, visit 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).

Year 2: Each quarter, the sites will be expected to show an increase in the percentage of patients that received surveys.

• **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:

Year 2: Each quarter, the sites will be expected to show an increase in the percentage of patients that receive shared decision making.

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 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 1, 2 & 3, 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).

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 1, 2 & 3.**

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 1, 2 & 3, 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 CSI portal, 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 1, 2 & 3, 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 1, 2 & 3, 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/about-hca/healthier-washington/medicaid-transformation-metrics#dsrip-outcome-metrics
- 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. ADD: Minimum internal monthly meetings- **mandatory**

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

2. **Year 2:** Please attest that your organization conducts internal Quality Improvement meetings. These meetings should occur without the Practice Transformation Navigators

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
	Select if appropriate

○ 12-19 Years	
• 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 CQMs for the practice site.

• Weekly **(Mandatory in Year 2)**	Select if appropriate
• Monthly **(Mandatory in Year 2)**	Select if appropriate
• Quarterly (Only applicable for Year 1)	Select if appropriate
• Our EHR cannot support practice site level reports. (Only applicable for Year 1)	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.

Year 2: Please upload a sample report

• Weekly **(Mandatory in Year 2)**	Select if appropriate
• Monthly **(Mandatory in Year 2)**	Select if appropriate
• Quarterly (Only applicable for Year 1)	Select if appropriate
• Our EHR cannot support practice site level reports. (Only applicable for Year 1)	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.

Year 2: Please attest that your organization, at minimum, met with your Practice Transformation Navigator monthly

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 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 1, 2 & 3, practices will reach out to willing partners. In PY 1, 2 & 3, 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 1, 2 & 3, you will reach out to willing partners. In PY 1, 2 & 3, 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]

1. Please attest that your practice is using at least one of the following tools: Collective Medical (EDIE and PreManage). **Mandatory**

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. Please attest that your practice is using Direct Secure Messaging. Please specify the organization used for this platform.

Attest Yes: Please attest that your practice is using Direct Secure Messaging.	**Attest No:** The organization is not using Direct Secure messaging
Select if appropriate and specify who is the Direct Secure Messaging provider	Select if appropriate

3. Please attest that your practice is using OneHealthPort. **Mandatory by Q2**

Attest Yes: Please attest that your practice is using OneHealthPort	**Attest No:** The organization is not using OneHealthPort
Select if appropriate	Select if appropriate

4. Building on your practice's activities. Further detail the requirements of each option below. Please note: The selection made in Quarter 1 cannot be changed in subsequent quarters.

   Year 2: All three selections will be **Mandatory**

• **Selection A (Clinic):** Follow up Contact within one week of ED Discharge. Each quarter, the sites will be expected to show an increase in the percentage of patients that received an ED follow up call; with an ultimate goal of achieving 95%.	Select if appropriate
• **Selection A (Hospital):** Identify patients without PCP and make referral	Select if appropriate
• **Selection B (Clinic):** Follow up Contact within 72 hours of IP Discharge. Each quarter, the sites will be expected to show an increase in the percentage of patients that received an IP follow up call; with an ultimate	Select if appropriate

goal of achieving 95%.	
• **Selection B (Hospital):** Identify patients without PCP and make referral	
• **Selection 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.

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

Emergency Department	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 will be expected to show an increase in the percentage of patients that received an IP follow up call; with an ultimate goal of achieving 95%.

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 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 1, 2 & 3 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, 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 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 1-4] [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.

   Year 2: There will be **mandatory** Learning Collaboratives on: Billing training, Shared Care Plans, Shared Decision-Making aids, and Self-Management tools.

• Community Our Practice Site participated in the above activities during our current Program Year	Select if appropriate
• Our Practice Site DID NOT participate in the above activities during our current Program Year – 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 our current Program Year.	Select if appropriate
• Our Practice Site DID NOT participate in the above activities during our current Program Year- 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 our current Program Year	Select if appropriate
• Our Practice Site DID NOT participate in the above activities during our current Program Year - 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 our current Program Year.	Select if appropriate
• Our Practice Site DID NOT participate in the above activities during our current Program Year - 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
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 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] - Mandatory

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

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 –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