JULY 2019

GREATER COLUMBIA
ACCOUNTABLE COMMUNITY OF HEALTH

QUALITY IMPROVEMENT PLAN

Greater Columbia Accountable Community of Health (project areas 2A, 2C, 3A, 3D)
Quality Improvement Plan

Develop continuous quality improvement strategies, measures, and targets to support the selected approaches (Completion no later than DY 3, Q2)

Greater Columbia Accountable Community of Health (GCACH) is using the transformative model of care called the Patient-Centered Medical Home (PCMH) as its framework for quality improvement (QI). Based on the principles of the Chronic Care Model, the PCMH model uses evidence-based guidelines, applies population health management tools, and demonstrates the use of "best practices" to consistently and reliably meet the needs of patients while being accountable for the quality and value of care provided. The PCMH model delivers whole-person care that is team based and coordinated, based on data, and measured continuously for quality improvement. The PCMH model incorporates evidence-based practices from the four project areas that GCACH has chosen: bi-directional integration, chronic disease management, transitional care and the opioid crisis.

Providers that contract with GCACH receive hands-on technical assistance by Practice Transformation Navigators (PTNs), trained on the AHRQ PCMH's Primary Care Practice Facilitation Curriculum and the Safety Net Medical Home Initiative resources and tools. PTNs guide clinics through the PCMH transformation through assessments, training on population health management tools like registries, risk stratification, and decision tools. They identify barriers, provide resources, and troubleshoot issues.

However, the formation of a QI team is a requirement and milestone of each partnering provider clinic or hospital. Improvement work invariably involves work across multiple systems and disciplines within a practice. The QI team is the group of individuals within a practice charged with driving quality improvement efforts. One of the first tasks to complete with the QI team is to identify goals for the improvement work and associated performance metrics, and it is recommended that the team is comprised of a cross-sector workgroup (clinicians, IT, senior leadership, finance, etc.) from within the organization.

PTNs make site visits to each participating clinic at least once a month, and meet with the QI team to review progress, discuss barriers or challenges, and to make adjustments to their workplans. PTNs also communicate regularly with the QI team to answer questions and to send resources and tools that will help them through the various milestones.

The PCMH model entails numerous changes to the clinic's business model; from claims and billing processes, to workflows and scheduling systems, to EHR configurations and organizational culture. GCACHs PTNs provide resources and guidance to help each clinic, hospital, and practice be successful throughout the practice transformation journey, working with the QI teams, or specific departments within the organization. The Practice Transformation Implementation Workplan (PTIW) is a living document that records the Plan Do Study Act (PDSA) cycle and guides the improvement process. The PTIW is reviewed on a quarterly basis, and is one of the incented milestones that is reported on.

The PCMH model incorporates regional Learning Collaboratives that bring together the QI teams from hospitals or clinics that are seeking improvement in a focused topic area. Learning Collaborative sessions vary from two hours to two days; depending on content, interest level to providers, and project area. Learning Collaborative sessions occur on a monthly cadence. The sessions often use representatives from exemplar organizations (e.g. federally qualified health centers) from within the PCMH cohorts, and other subject matter experts who share best practices, lessons learned, and success stories. Learning through this process has helped Practice Transformation organizations in their implementation of PCMH. Participation in the Learning Collaboratives are also a requirement of Practice Transformation organizations who undertake Practice Transformation with GCACH. PCMH success stories are also shared in the monthly Community Newsletter that is distributed to over 1,100 individuals associated with GCACH, and reviewed monthly with the GCACH Board of Directors.

Providers work from a guidebook called the *Practice Transformation Reporting Workbook* that is modeled after the Center for Medicare and Medicaid Innovation's (CMMI) Comprehensive Primary Care's (CPC) Implementation and Milestone Reporting Summary Guide. The workbook has been customized to meet the needs of the Medicaid Transformation (MT) and contains milestones and reporting measures linked to the MT project areas and to PCMH/Practice Transformation concepts. These milestones are evidence-based and critical to health care delivery transformation. However, the GCACH takes a very collaborative approach and is flexible with PT organizations doing the work. The workbook has been described "descriptive without being too prescriptive" and offers providers flexibility in designing their change programs, allowing them to choose the targets and measures that they want to track and report on within the project areas. Beginning in July 2019, the PT organizations will begin recording their progress in a web-based portal site (Healthcare Communities portal) to track progress in completing PCMH milestones.

Finally, the process is overseen, monitored and evaluated by the Practice Transformation Workgroup (PTW), a chartered committee selected by the GCACH Board of Directors and comprised of clinical providers and subject matter experts in quality improvement, population health management, complex case management, and workforce development. The PTW meets quarterly to review the results of each cohort using the Practice Transformation Scoring Report. The Practice Transformation team presents an overview of the progress of each participating provider in the four project areas, barriers to implementation, and highlight success stories. The PTW offers guidance and adjustments to the process.

The following quality improvement steps were extracted from the Quality Improvement sections of the Project Area in the Implementation Plan, Semi-Annual Report 2.0 (SAR 2.0) and are common to all four project areas:

> **Step 1:** Create an advisory committee of subject matter experts with C-suite representation from large, medium and small practices to guide the transformation project, review the process for PCMH transformation, study the results, and monitor the progress. Engage these leaders to understand, facilitate, and advocate transformation within their organizations, and to become disciples of the PCMH care model. Their responsibilities include:

- Reviewing regional data and helping identify the appropriate selection criteria for providers to receive PCMH technical assistance;
- Selecting providers to engage in the PCMH transformation process;
- Reviewing GCACH provider assessments and identifying regional strengths and weaknesses to better inform the selection of providers and application of change strategies;
- Monitoring PCMH provider performance and making any necessary adjustments in strategy or tactics.

STATUS: The Practice Transformation Workgroup (PTW) was chartered in January 2018, and met twice a month from February to October 2018. In April 2018, GCACH staff introduced the PCMH model as the framework that met many of the Medicaid Transformation objectives regarding value-based payments, chronic care management, bi-directional integration, care coordination, transitional care, and the social determinants of health. In 2019, the meetings moved to a quarterly cadence in order to review the quarterly reports from the participating Provider organizations.

Step 2: Create a standardized method to assess the readiness and willingness of potential participating Providers to undertake practice transformation, and the PCMH model. Use the following change concepts to assess Provider readiness: Leadership, Transparency, Collaboration, Adaptive, Value-Driven and Equity. Prioritize Provider list based on independent analysis of adherence to change concepts.

STATUS: The Current State Assessment (CSA) tool was initially used in May 2018 to choose the first PCMH cohort, and was scored by Oregon Health Sciences University research staff in July 2018. OHSU scored the CSAs and made recommendations for high, medium, and low levels of readiness for practice transformation. The PTW used the OHSU recommendations and factored in geographic equity across the nine counties to finalize the list of PT organizations. The same process will be used to add future cohorts to the PCMH program.

Step 3: Develop Milestone reporting measures that align and reinforce the PCMH change concepts and project areas. Incorporate milestones in Provider contracts. Contracts developed based on a revenue sharing model that rewards completion of the milestones. Milestones are weighted, and based on work tasks that build capacity in the organization, develop and enhance population health management tools like risk stratification and decision-making tools, EDIE and PreManage, and track clinical quality measures chosen by PCMH organizations. Host a Learning Collaborative meeting to explain contract, revenue sharing model, and reporting milestones. Incent attendance for Partnering Providers.

STATUS: All contracts with PCMH Cohorts include the revenue sharing model, deliverables, and Implementation Toolkit. The PCMH contract was thoroughly reviewed with all of the

PCMH Cohort #1 providers on January 3, 2019 and attendance was required. All contracts were signed by April 14th. (See attached contract, and *Practice Transformation Implementation & Reporting Toolkit* for more detail. Example of revenue sharing model for one organization below.)

Milestones	2019 Quarterly Maximum Revenue Sharing based on Milestones				
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
1A.1/1A.2 Budget	$2,433	$0	$0	$2,433	$4,866
2A.1 Empanelment	$2,433	$2,433	$2,433	$2,433	$9,732
2A.2/2A.3 Risk Stratification/Two Additional Opportunities	$2,433	$2,433	$2,433	$2,433	$9,732
2B.1 Bi-Directional Integration	$0	$7,298	$0	$7,298	$14,596
2B.2/4A.2 Self-Management Support/Shared Decision Making	$1,217	$1,217	$1,217	$1,217	$4,868
2B.3 Care Management	$3,650	$3,650	$3,650	$3,650	$14,600
3A.1 Access and Continuity	$3,650	$3,650	$3,650	$3,650	$14,600
4A.1 Patient and Family Engagement (Update Quarter Distribution Based on Selection)	$2,433	$2,433	$2,433	$2,433	$9,732
5A.1 QI Team	$15,000	$0	$0	$0	$15,000
5A.2 Reporting	$12,165	$12,165	$12,165	$12,165	$48,660
5A.3 PTIW	$1,217	$1,217	$1,217	$1,217	$4,868
6A.1 ED and Hospital Follow-up	$3,650	$3,650	$3,650	$3,650	$14,600
6A.1 Hospital Utilization	$3,650	$3,650	$3,650	$3,650	$14,600
7A.1 Training/Mentoring	$0	$0	$0	$9,732	$9,732
7A.1 Practice Transformation Learning Collaboratives	$0	$0	$0	$14,598	$14,598
8A.1 Implementation of PM/EDIE (Once Completed PY2019 Payment will be made)	$4,866	$0	$0	$0	$4,866

8A.1 PCMH-A	$10,000	$0	$0	$0	$10,000
8A.1 MeHAF	$10,000	$0	$0	$0	$10,000
8A.1 Base Population Health Funds	$140,000	$0	$0	$0	$140,000
8A.1 Assessments (HIT/EHR)	$4,866	$0	$0	$0	$4,866
8A.1 Health Information Technology	$4,866	$0	$0	$0	$4,866
Total 2019 Maximum Available Revenue Sharing	$141,029	$43,796	$36,498	$70,559	$379,382

Step 4: Develop Learning Collaboratives specific to the needs of PT organizations for successful implementation of the change concepts and evidence-based practices in the four project areas: Bi-Directional Integration, Opioid Crisis, Chronic Disease Management and Transitional Care. Trainings will be identified to support the project areas from the Current State Assessment (CSA) tool, the PCMH-A and MeHAF assessments. Provide in-person assistance through site visits, technical training, or opportunities for the providers to participate in training seminars, webinars, and learning sessions as part of Quality Improvement program. Learning Collaboratives provide learning opportunities on how to achieve milestones in the contract working in collaboration with PT Navigators, Director of Practice Transformation, and exemplar organizations.

STATUS: A curriculum for the Learning Collaboratives, based on the milestones and Current State Assessment results has been developed, and monthly Learning Collaborative sessions have been in effect since January 2019. To date the following sessions have covered:

- Reviewing the PCMH contract – January (2.5 hours)
- Reviewing and Developing a Budget – February (2 hours)
- Behavioral Health Integration with Exemplars – March (2.5 hours)
- EMS and Community Paramedicine – April (2.5 hours)
- PDMP, Medication Management, P4R, MAT training – May (2.5 hours)
- Opioid Use Disorder and Trauma Informed Care Summit – June 20-21 (2-day event)

The curriculum for the rest of the year includes:

- Access and Continuity and the CSI Portal – July 19 (2.5 hours)
- Chronic Disease, Self-Management Support, Motivational Interviewing, Transitional Care Management – August 1-2 (2-day event)
- QI Metrics/VBP and technology – September 19 (2.5 hours)
- Exemplar clinics with residency programs – October 19 (2.5 hours)
- Lessons Learned and Success Stories – November 15 (2.5 hours)

The Opioid Use Disorder and Trauma Informed Care Summit was a two-day event attended by more than 250 providers, offered Continuing Medical Education credits and included 30 speakers who were national, state, regional and local experts in their respective areas. The four learning tracks included the following:

- Strategies for Managing Patients with OUD
- Patients, Payment, and Stigma
- Trauma Informed Care
- Innovative Models of Care

Each Partnering Provider selected for PCMH receives $14,598 for attending Learning Collaborative sessions based on the evidence-based practices and change concepts. Ideally, all members of the PT organization's Quality Improvement Team attend the in-person sessions held by GCACH, but credit is given for attending learning webinars remotely, or attending other learning webinar or professional development activities. Partnering Providers must attest to their participation in the Learning Collaboratives, Leadership Council meetings, monthly webinars, or other professional development opportunities.

Step 5: Develop monitoring process through GCACH online Reporting Platform (CSI Healthcare Communities) using outside IT vendor, develop internal monitoring processes through PCMH Trackers, Practice Transformation Implementation Workplan (PTIW), Practice Transformation Reporting Workbook, Quarterly Reporting, and One-on-One technical assistance from Practice Transformation (PT) Navigators.

STATUS: GCACH developed a reporting workbook to track quarterly PCMH milestones, and report progress for implementation activities. The reporting workbook tracks achievement through data, narratives, or through a selection of options. The reporting workbook will be transitioned over to an online web-based reporting portal, that will upload PT organization milestone data to report progress. The PTIW creates the baseline for the change concepts, and records monthly site visits.

Step 6: Monitor Progress of milestones through GCACH online reporting portal, IMC and PCMH Trackers, Practice Transformation Implementation Workplan, Quarterly Reporting, and site visits from Practice Transformation Team. Contract deliverables include Practice Transformation change concepts and milestones, assessments, clinical quality measures, population health management implementation.

STATUS: Quarter 1 milestones were reviewed by the Practice Transformation Workgroup on May 2nd which included Assessments (MeHAF, PCMH-A, HIT/HIE), year-to-date payments to each Partnering Provider, status on each project area, and a list of barriers if implementation

has been delayed. (See Practice Transformation Scoring Report for more detail.) The site went live on June 17, and Quarter 1 reports were pre-loaded by the PT Navigators. PT organizations will be able to view this Q1 data when they begin to enter their Q2 reporting milestones due July 15. GCACH and CSI conducted online trainings for using the reporting portal on June 26th, and any organization can receive one-on-one technical assistance from GCACH staff. Additionally, PT Navigators meet with each clinic monthly to track progress toward change concepts and goals in the PTIW, and track the progress of each clinic on a monthly basis which is reported out at the monthly Board meetings. If organizations have a deficiency during the reporting period, the Practice Navigator will do a follow up with the clinic to discuss the deficiency. The clinic will then have a 6-day grace period to work with the Practice Navigator to correct the deficiency in order to receive the full value of the point system assigned to that milestone. The Director of Practice Transformation will reevaluate the deficiency for full, partial or no point payment. Additionally, PT Navigators refer to the PTIW for baseline data, and to record monthly site visits. Milestone progress for each clinic is reported out at the monthly Board meetings through the PCMH or IMC Tracker document. After Quarter 2 reports have been input into the Portal, GCACH will work with CSI on a Reporting Dashboard to capture aggregated data that best represents cohort progress toward implementing the milestones.

Step 7: Share results with PTW and Providers. Adjust measures and processes as needed to implement change concepts by PCMH Cohort, and review with PTW. PT Navigators review progress towards milestones with Partnering Providers with every site visit.

STATUS: Milestones are continuously reviewed for each Partnering Provider by the Practice Transformation Navigators at their monthly site visits to make progress toward transformation efforts. Quarter 1 milestones were reviewed by the Practice Transformation Workgroup on May 2nd which included year-to-date payments to each Partnering Provider, status on each project area, and a list of barriers if implementation has been delayed.

Step 8: Assess each work step and Provider resources for successful implementation of population health management tools (e.g., staffing for risk stratification, enhancements to EHR, PMP), and how they will improve health systems, community capacity building, and health equity.

STATUS: The Practice Transformation Team meets with each Partnering Provider organization monthly to ensure that they are making progress toward using population health management tools, and selecting quality metrics. The Executive Director, Deputy Director, Finance and Contract Director, and the Practice Transformation Director started an initiative in May 2019 to make site visits with hospital and clinic leadership to ensure that transformation efforts, reporting requirements, milestones, Learning Collaboratives, and implementation of population health management tools are going smoothly, and to determine if any mid-year corrections to the transformation process are needed.

Site visits with the following Partnering Providers have been accomplished:

- Astria Toppenish Hospital, Astria Sunnyside, Astria Yakima
- Kadlec Regional Medical Center/Providence St. Mary's Hospital
- Virginia Mason Memorial Hospital
- Garfield Hospital
- Pullman Hospital
- Columbia County Health System
- Kittitas Valley Healthcare
- Tri-Cities Community Health
- PMH Medical Center
- Lourdes Health Network
- Yakima Neighborhood Health Services
- Quality Behavioral Health

These meetings have been extremely productive, and Leadership from these organizations are reporting favorable feedback regarding the Practice Transformation Navigator's technical assistance in finding resources, re-thinking workflows, and re-evaluating PCMH strategies. They seem pleased with the "descriptive but not prescriptive" nature of the PCMH program as it allows them flexibility to use their revenues to meet local needs, however the lack of structure also creates confusion among some provider organizations. Greater Columbia is using this feedback to make improvements to the reporting platform, to minimize the work in reporting on milestones, and to get referrals for potential Partnering Providers for future cohorts.

Step 9: Health Care Partners, Primary Care, and Behavioral Health develop and agree on shared care plans, how to exchange information. Training for an implemented shared care plan dependent upon specified evidence-based model, e.g., Transitional Care Model, Community Para-medicine model.

STATUS: GCACH contracted with Quad Aim Partners to develop a community information exchange (CIE) called the Health Commons to electronically connect health and social service providers together to improve patient/client care transitions between agencies. Through a competitive process, the Kittitas County Healthcare Network was chosen to pilot this project as they had an established network of providers identified as "The A Team" that were trying to develop such a system, and were relying on manual processes to manage patients common to their organizations. The CIE manages digital consents, health record integration and information exchange. Patient Health Information (PHI) is stored on Amazon Microsoft's secure cloud infrastructure and is under contract to Quad Aim Partners to ensure proper technology integration as well as quality and consistency of service. The pilot includes Kittitas Valley Fire and Rescue Paramedics, Kittitas Valley Healthcare, and Comprehensive Mental Health, and will add additional partners after successfully demonstrating a live patient experience.

Additionally, GCACH has a Memorandum of Understanding with the Yakama Nation to implement a Health Commons that will connect several programs related to family reunification. The Yakama Nation will be working with Quad Aim to organize and digitally connect services to a community-wide care coordination system.

Practices are also encouraged to use direct secure messaging. Direct secure messaging is an electronic communication technology, that sends messages and data packets between provider EHRs but also includes secure (HIPAA-compliant) web e-mail to communicate with organizations with no EHR. It is designed typically for the exchange of patient health information but can also convey information relating to a patient's social service needs.

GCACH is also working with Collective Medical and the Managed Care Organizations to implement EDIE and PreManage. EDIE is a care management tool that provides alerts to emergency department providers regarding patients who visit the emergency department more than five times or have an inpatient admission in a 12-month period. PreManage combines information from participating healthcare partners, including hospitals and emergency departments (EDs), primary care practices, and behavioral health agencies (BHA), and synthesizes the information into brief, actionable information about individual clients. It is a valuable tool for identifying and tracking high-risk, high-utilizing clients and assisting providers with developing strategies to stabilize clients and reduce unnecessary hospital and emergency department (ED) utilization by facilitating real-time alerts and care coordination. In its implementation, the GCACH seeks to find ways to full integrate PreManage into the practice's EHR, reducing the need for a separate sign-on for accessing data.

Step 10: Scale and Sustain

STATUS: GCACH selected a second Cohort in May 2019 (Scale), the seventeen community Behavioral Health organizations that transitioned to Managed Care in January 2019. These organizations will be using the same QI model, PCMH, to transform their practices. While integration with primary care is preferred, the BH agencies will have flexibility in developing their integration models. Integrating with SUD or mental health agencies, schools, dental offices, skilled nursing facilities, emergency departments, fire departments, or other community settings is encouraged.

A third cohort is planned for October 2019. The third cohort will be comprised of remaining hospitals that want to incorporate PCMH change concepts, additional clinics with large Medicaid populations in Yakima and Benton Counties, and possibly, care coordination and transitional care facilities such as skilled nursing facilities, and palliative care programs. GCACH is using the same process to select the third cohort; LOI/CSA submission, independent scoring, PTW confirmation, and Board approval. As the composition of the cohorts evolves, the LOI/CSA is revised to include questions specific to that aspect of the healthcare delivery system.

GCACH has modeled its projected cash flow through 2023 (Sustain), and has committed to fund all three cohorts through 2022. Funding steps down from approximately $283,598 in year 1, to $149,454 in year 2, to $74,727 in year 3. During this time, each organization will have received technical assistance on evidence-based practices in all four project areas, and training on how to maximize claims reimbursements based on delivering quality care, and how to negotiate a contract with managed care organizations that is value based. Below is the Scale and Sustain funding model for all three Practice Transformation cohorts:

Schedule 1 - Calculator for projecting the number of sites participating in Cohort 3									
Project Incentive Payments to Partners	# Partners	Unit Value**	2018	2019	2020	2021	2022	2023	Total
Cohort 1 Partners (JAN-DEC)									
PCMH Transformation Incentives (base)	45	$283,597	$0	$12,761,879	$0	$0	$0	$0	$12,761,879
Scale and Sustain Allowances (1)	45	$149,454	$0	$0	$6,725,430.00	$0	$0	$0	$6,725,430
Scale and Sustain Allowances (2)	45	$74,727	$0	$0	$0	$3,362,715.00	$0	$0	$3,362,715
Subtotal - Cohort 1 Partners			$0	$12,761,879	$6,725,430	$3,362,715	$0	$0	$22,850,024
Cohort 2 Partners - BHO Partners (JUL-JUN)									
PCMH Transformation Incentives (base)	17	$247,745	$0	$1,899,025	$2,312,640.97	$0	$0	$0	$4,211,666
Scale and Sustain Allowances (1)	17	$149,454	$0	$0	$1,080,554	$1,046,554	$0	$0	$2,127,108
Scale and Sustain Allowances (2)	17	$74,727	$0	$0	$0	$540,277	$730,082	$0	$1,270,359
Subtotal - Cohort 1 Partners			$0	$1,899,025	$3,393,195	$1,586,831	$730,082	$0	$7,609,133
Cohort 3 Partners - TBD (OCT-SEP)									
PCMH Transformation Incentives (base)	24	$283,598	$0	$1,650,495	$5,155,859	$0	$0	$0	$6,806,354
Scale and Sustain Allowances (1)	24	$149,454	$0	$0	$699,168	$2,887,728	$0	$0	$3,586,896
Scale and Sustain Allowances (2)	24	$74,727	$0	$0	$0	$349,584	$1,443,864	$0	$1,793,448
Subtotal - Cohort 3 Partners			$0	$1,650,495	$5,855,027	$3,237,312	$1,443,864	$0	$12,186,698
Total Incentive Awards - All Cohorts			$0	$16,311,398	$15,973,652	$8,186,858	$2,173,946	$0	$42,645,854
FINANCIAL PLAN ALLOWANCE FOR PROJECT INCENTIVE PAYMENTS TO PARTNERS			$4,495,435	$16,744,012	$10,537,006	$9,327,007	$4,428,503	$0	$45,531,963
**Unit Values are fixed and derived from the schedules in Sam's Worksheet.				Balance - Unallocated Project Incentives for Partners based on Financial Plan					$2,886,108

A Component of the Quality Improvement Plan

GREATER COLUMBIA
ACCOUNTABLE COMMUNITY OF HEALTH

Patient Centered Medical Home Change Concept: 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.

GCACH Practice Transformation (PT) Resources

- PT Toolkit
- Learning Collaboratives
- Exemplar organizations
- Technical assistance
- Healthcare Communities portal resources
- Practice Transformation Implementation Workplan
- Assessments

GCACH Practice Transformation Toolkit: Milestone 5 – Quality Improvement

- Milestone 5 guides PT organizations to take a systematic, data driven approach to drive quality improvement.
- Organizations will identify measures for quality and utilization that are important to them and their patients. They will use these Clinical Quality Measures (CQM) as guides while they test changes to their practice.
- Milestone 5 also requires that PT organizations create a Quality Improvement team that will be directed toward achieving the GCACH Milestones and working with its Practice Transformation Navigators.

Practice Transformation Organizations

PT Milestone Reporting

- PT organizations transmit Milestone reporting deliverables to GCACH
- Uploaded CQMs correspond to MTP Pay-for-Performance measures

GCACH Practice Transformation Workgroup (PTW) Review

- PTW reviews PT Milestone reporting results on a quarterly basis
- Obstacles to Practice Transformation implementation are assessed
- Possible solutions are identified

Improvement Strategy Translation

- GCACH responds and assimilates findings from PTW review and translates them into PT process changes

Revised: 7-27-2019