



GREATER COLUMBIA

ACCOUNTABLE COMMUNITY OF HEALTH

**QUALITY IMPROVEMENT PLAN
JANUARY 2020**

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

Develop continuous quality improvement strategies, measures, and targets to support the selected approaches

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 identified in the Healthier Washington Medicaid Transformation Project Toolkit and from the four MTP project areas that GCACH has chosen:

- Project 2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation
- Project 2C: Transitional Care
- Project 3A: Addressing the Opioid Use Public Health Crisis
- Project 3D: Chronic Disease Prevention and Control

Providers that contract with GCACH receive hands-on technical assistance by Practice Transformation Navigators (PTNs). The Director of Practice Transformation has put together an extensive training program using the Agency for Healthcare Research and Quality’s (AHRQ) Primary Care Practice Facilitation Curriculum and the Safety Net Medical Home Initiative PCMH implementation guides. The curriculum is continuously supplemented with the latest resources and evidence-based tools.

PTNs guide clinics through PCMH transformation through assessments, training on population health management tools like registries, risk stratification, and decision tools. They identify barriers, provide resources, assist in implementation 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 opportunities 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. As of 12/31/2019, the sixty-two clinic sites contracted with GCACH for Practice Transformation represent over nine-hundred QI team members and providers that serve over seven hundred thousand patients (all-payers) in Greater Columbia ACH’s service area.

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 each 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. 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 change plan for each site and a living document that integrates the PCMH-A and/or MeHAF assessment results incorporated into a 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 and 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 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 Change Concepts: please see Figure 1.



Figure 1; PCMH Change Concepts

Feedback from the providers has indicated that they would rather learn from their peers than bring in subject matter experts from outside the region. How to change the culture of an organization, how to integrate behavioral health and primary care, and how to effectively use nurse case managers for transitional care are examples of site visits for peer learning within the GCACH region.

Participation in the Learning Collaboratives is also a Milestone requirement of Practice Transformation organizations who contract with GCACH. Providers must attest that they have participated in at least four Learning Collaborative sessions during the year to meet that Milestone.

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 by 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) program and contains Milestones and reporting measures linked to the MT project areas, to PCMH/Practice Transformation concepts, and to statewide measures (MT Pay-for-Performance). 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. In this manner, providers are introduced to a fairly rigorous form of value-based contracting, and their level of attainment and improvement are both rewarded. Patients are also treated more proactively through a planned model of care. Quality is built into the Milestones for which the providers are rewarded. Beginning in July 2019, the PT organizations will begin recording their progress in a web-based portal site (CSI Healthcare Communities portal) to track progress in completing PCMH Milestones. Through this reporting portal, PT organization will upload PT Milestone data on a quarterly basis.

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 across the four project areas, indicates barriers to implementation in the prior reporting quarter, and highlights success stories from the PT organizations in their implementation work. The PTW offers guidance and adjustments to the process and this is integrated into changes in the overall Practice Transformation process.

SAR 4.0 UPDATE: Provider results are also reviewed by the Board of Directors, and beginning in 2020, CSI Solutions will be producing an aggregate report in the form of a dashboard to enable providers to visualize their progress, and compare their progress with other sites. Each site will be assigned an anonymous ID so their site identity will remain unknown. However, the data will aggregate all eighty-three sites across twelve measures. The twelve dashboard measures are those that will give GCACH staff the greatest insight into how sites progress using population health management tools, approach care coordination, and progress under the quality metrics they are gathering. The twelve dashboard measures are:

- Top Ten Clinical Quality Metrics
- Care Management for High Risk Patients
- Empanelment Rate
- Top Five Risk Stratification Methods

- Care Coordination Options
- Behavioral Health Integration Models
- Medication Management Services
- Follow-up within One Week of ED Discharge
- Follow-up within 72 Hours of Hospital Discharge
- High Referral Community Partners
- Identify Patients Needing Integrated Care
- Behavioral Health Integration Assessment Tools

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 MT 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.
- Reviewing and recommending changes to the Milestones for years two and three of the Transformation program.

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.

SAR 4 UPDATE: GCACH has added two additional Cohorts since June 30, 2019. The second Cohort includes the seventeen behavioral health agencies that transitioned to integrated managed care (IMC) in 2018. Upon receipt of the second phase of IMC funding in April 2019, GCACH staff recommended to the Provider Readiness Group and the Budget and Funds Flow Committee that \$4.2 million of the \$6.1 million be distributed according to the same Practice Transformation revenue sharing model as Cohort 1. While it would not be expected of the

behavioral health agencies to achieve all of the Milestones of Cohort 1 for Practice Transformation, it would honor the expectations of the Washington State Health Care Authority to support implementation of a fully integrated physical health and behavioral health managed care system. This recommendation was forwarded by these committees and approved by the Board of Directors.

While the behavioral health agencies were skeptical that Practice Transformation applied to their clinics, they have quickly embraced transformation concepts, and are eagerly making changes within their workflows and practices. Their earlier suspicions about the GCACH have also dissipated as well. GCACH has allowed more flexibility in their integration models, and are seeing innovative partnerships such as integrating mental health and behavioral health services, offering mental health services in a school setting, screening for behavioral health in a dental setting, and offering primary care in a SUD clinic. This has pushed integration approaches to new limits.

GCACH had more difficulty in assembling the third Cohort, in spite of the possible substantial financial incentives. While roughly the same process was used for sending out the Letter of Interest/Current State Assessment application and scoring them upon receipt, fewer providers responded. So the GCACH Board allowed for a "rolling start" through the end of November to allow time for GCACH staff to go back to specific providers to give them more information about the PCMH program. GCACH solicited independent primary care offices with medium to large Medicaid populations, and organizations referred to the GCACH by Practice Transformation organization CEOs during our mid-year check-ins. Most of the independent practices did not seem to understand the 1115 Waiver and were not ready for transformation within their clinics. However GCACH was able to attract a mix of palliative care agencies, skilled nursing facilities, and additional primary care clinics from larger health systems, again pushing the Practice Transformation process to new frontiers. There are twenty-one clinics in the third Cohort, and they are still finalizing contracts and determining practice sites. With the addition of the second and third Cohorts, GCACH will have eighty-three sites doing Practice Transformation using all or part of the PCMH framework.

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 by Oregon Health Sciences University (OHSU) to score the provider organization applications 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.

SAR 4 UPDATE: GCACH combined the Letter of Interest and Current State Assessment documents (LOI/CSA) in August 2019 to streamline the application process and remove redundant questions across both documents for the third Cohort. Scoring for the third Cohort was done by OHSU, and the third Cohort is provided the opportunity to earn incentive funding using the same revenue sharing model as Cohort 1.

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 2019 is shown in Figure 2.

EXHIBIT "A1"
TRANSFORMATION INCENTIVE ALLOCATION WEIGHTS AND VALUES-RICHLAND

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

Partnering Clinic: Catholic Charities Serving Central Washington 2139 Van Giesen St. Richland, WA 99352

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 QJ Team	\$7,500	\$0	\$0	\$0	\$7,500
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	\$5,000	\$0	\$0	\$0	\$5,000
8A.1 MeHAF	\$5,000	\$0	\$0	\$0	\$5,000
8A.1 Base Population Health Funds	\$70,000	\$0	\$0	\$0	\$70,000
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	\$291,882

Figure 2; 2019 Revenue Sharing Model

SAR 4 UPDATE: GCACH developed a revenue sharing model that includes incentive funding for a three-year period. Technical assistance will be provided to each site during this timeframe with the expectation that sites will adapt to the Change Concepts and processes for each Milestone. Incentive funding decreases in a step-down fashion from Year One to Year Three, however. Please see Figure 3. Emphasis on the following Milestones in Year Two builds on the processes and evidenced-based practices introduced in Year One: Budgeting, Care Management, Bi-Directional

Integration, QI Team, Reporting, PTIW, Attestations, Care Coordination, Training and Mentoring, Learning Collaboratives, and the PCMH-A and MeHAF assessments.

AMENDMENT FORM
NO. 1

Pursuant to Section 15, the following changes are hereby incorporated into this Contract:

- A. Description of Change: Extend the Completion Date to January 15, 2021 and replace Exhibit "A.1" and Exhibit "A.2" Transformation Incentive Allocation Weights and Values Revenue Sharing Model in its entirety with the following:

Maximum Available Revenue Sharing for 2020 Scale and Sustain

Partnering Clinic: Catholic Charities Serving Central Washington 2139 Van Giesen St. Richland, WA 99352

Milestones	2020 Quarterly Maximum Revenue Sharing based on Milestones				
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
1A.1 Budget/1A.2 Budget Reconciled	\$1,217	\$0	\$0	\$1,217	\$2,434
Care Management (\$9,000 total per quarter)					
2A.1 Empanelment	\$1,125	\$1,125	\$1,125	\$1,125	\$4,500
2A.2.A Risk Stratification/2A.2.B Risk Stratification Statistics	\$1,125	\$1,125	\$1,125	\$1,125	\$4,500
2A.3 Opportunities for those at Highest Risk	\$1,125	\$1,125	\$1,125	\$1,125	\$4,500
2B.2 Self-Management Support	\$1,125	\$1,125	\$1,125	\$1,125	\$4,500
2B.3.A Medication Management	\$1,125	\$1,125	\$1,125	\$1,125	\$4,500
3A.1 Access and Continuity	\$1,125	\$1,125	\$1,125	\$1,125	\$4,500
4A.1 Patient Centered Interactions	\$1,125	\$1,125	\$1,125	\$1,125	\$4,500
4A.2 Shared Decision Making	\$1,125	\$1,125	\$1,125	\$1,125	\$4,500
2B.1 Bi-Directional Integration	\$3,649	\$3,649	\$3,649	\$3,649	\$14,596
5A.1 QI Team	\$3,750	\$3,750	\$3,750	\$3,750	\$15,000
Reporting					
5A.2 Clinical Quality Metrics	\$6,731	\$6,731	\$6,731	\$6,731	\$26,924
6A.2 MCO Roster Reporting	\$1,000	\$1,000	\$1,000	\$1,000	\$4,000
5A.3 Practice Transformation Implementation Workplan (PTIW)	\$1,217	\$1,217	\$1,217	\$1,217	\$4,868
6A.1 Attestations (Collective Medical, Direct Secure Messaging, One Health Port)	\$1,000	\$1,000	\$1,000	\$1,000	\$4,000
Care Coordination					
6A.1 Selection A (Clinic) Follow up contact within one week of ED Discharge					
6A.1 Selection A (Hospital) Identify patients without PCP and make referral					
6A.1 Selection B (Clinic) Follow up contact within 72 hours of IP Discharge	\$4,433	\$4,433	\$4,433	\$4,433	\$17,732
6A.1 Selection B (Hospital) Identify patients without PCP and make referral					
6A.1 Selection C-Care Compact/Agreements					
7A.1 Training/Mentoring	\$1,826	\$1,826	\$1,826	\$1,826	\$7,304
7A.1 Practice Transformation Learning Collaboratives	\$3,649	\$3,649	\$3,649	\$3,649	\$14,596
8A.1 Patient Centered Medical Home-Assessment (PCMH-A)	\$1,000	\$0	\$0	\$0	\$1,000
8A.1 Maine Health Access Foundation (MeHAF)	\$1,000	\$0	\$0	\$0	\$1,000
Total 2020 Maximum Available Revenue Sharing	\$39,472	\$36,255	\$36,255	\$37,472	\$149,454

Figure 3; 2020 Revenue Sharing Model

Additionally, some of the Year One Milestones will be mandatory in Year Two. Please refer to GCACH.SAR4 Attachment 16-2. 1.31.20

The following Milestones are mandatory or new Milestones in contract Year Two:

- Empanelment Status
- Review of Patient Rosters
- Increase target rate to risk stratify 85% of empaneled patients (up from 75% in Year One); provide care management to at least 95% of patients
- Screen for Social Determinants of Health

- Provide a concise narrative describing the approach methodology or tools used to stratify patients
- Record the total number of patients in each risk stratum and the number of patients within the stratum that received care management services
- Conduct a daily (in-person or electronic) team-based huddle
- Quantify the percentage of patients that have been assessed for behavioral health
- Sites will follow-up with patients after one no-show. Follow up can be completed via phone call or mailed letter
- Being trained in medication assisted treatment (MAT) having a MAT referral source will be required
- 10% of patients that have at least three high-risk conditions should receive self-management support
- Providers must identify measures that are tracking patients with three or more high-risk conditions
- Medication Reconciliation will be mandatory
- Engaging pharmacists will be mandatory (i.e. collaborated, integrated, contractual, tele-pharmacy)
- Collaborative Drug Therapy Management is mandatory for contracted or staffed pharmacists
- Clinic sites will report on third next available appointment for the following appointment types: Acute, Adult, Well-Child, and New Patient visits
- Clinics sites will determine what workforce or training is needed to provide patient-centered care (i.e., Community Health Worker, Behavioral Health Peer Specialist, ARNP, etc.)
- Each quarter, the sites will be expected to show an increase in the percentage of patients that received surveys
- Each quarter, the sites will be expected to show an increase in the percentage of patients that received shared decision-making tools
- QI teams must meet internally at least monthly
- Clinical Quality Measures (CQM) must be reviewed on a weekly or monthly cadence
- Practices will be required to create individual practitioner or care team CQM reports
- Monthly meetings with the Practice Transformation Navigator are mandatory
- The use of CollectiveMedical is mandatory 2020
- The practice must attest to using OneHealthPort by Quarter 2
- Sites will be expected to show an increase of the percentage of patients receiving follow-up calls after an ED visit or hospitalization
- The following Learning Collaboratives will be mandatory in 2020: Billing training, Shared Care Plans, Shared Decision-Making aids, and Self-Management tools

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.

SAR 4 UPDATE: The curriculum for the Learning Collaboratives in 2020 builds on Year One, and includes:

- Reviewing and Developing a Budget - January
- Crisis Services - February
- The Art of Person-Centered Care - March
- HIPAA Policy Changes - April
- Shared Decision Making and Self-Management Tools – June (Mandatory)
- Shared Care Plans – July (Mandatory)
- EHR breakout session - August
- How to Maximize Medicaid Reimbursements – September (Mandatory)
- Practice Transformation Recognition Dinner, Exemplar Panel - October
- Cultural Sensitivity/ Cultural Competency - December

There is one schedule for all Cohorts, and each site will be incented \$14,596 by attending four Learning Collaboratives throughout the year with three sessions that are mandatory. In 2020, the GCACH Marketing Department is teaming with the Practice Transformation Department to provide materials that relate to each topic. For example, GCACH will provide hot/cold packs for the Crisis Services Learning Collaborative session.

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.

SAR 4 UPDATE: All reporting is now accomplished through an online portal co-designed by CSI Solutions and GCACH. This has reduced manual reporting time for providers, and has given the Practice Transformation Team the ability to access provider data more easily and efficiently. A Dashboard consisting of twelve measures will be aggregated across all provider sites for an overall view of the progress of all three Cohorts.

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.

SAR 4 UPDATE: Four quarters of metrics are now available electronically through the CSI portal, and all Practice Transformation Cohort providers are entering quarterly data using the platform. The entry of data is much more efficient for both the providers and the Navigators. GCACH is recommending slight improvements to the Milestones. Drop-down menus, and automatic calculations for Milestones requiring numerator and denominator data make monitoring and evaluation more efficient for the Practice Transformation Team, however some erroneous data entry is occurring which is being corrected. The Reporting Dashboard is almost complete with weekly conference calls with CSI to work out the final details. The Dashboard report aggregates the reporting from all sixty-two clinic sites, allowing a quick analysis of twelve metrics as shown in Figure 4. Cohort 3 will be added once they begin quarterly reporting in April 2020.

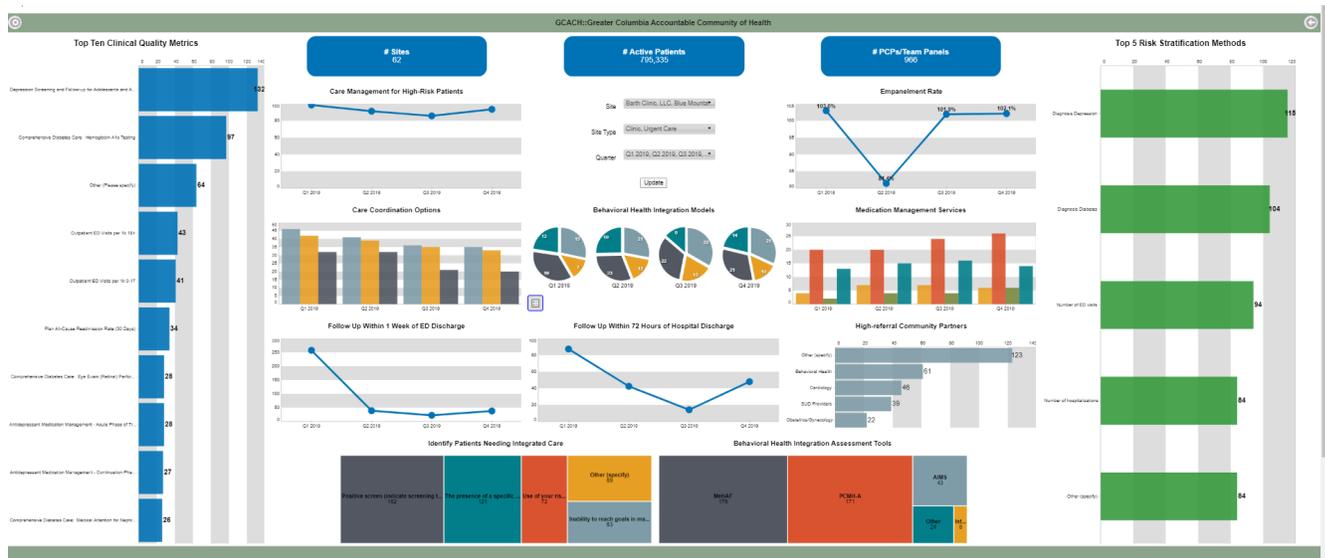


Figure 4; GCACH Reporting Dashboard

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.

SAR 4 UPDATE: Quarter 2 and 3 Milestones were reviewed by the Practice Transformation Workgroup on July 25 and November 7th. All organizations have implemented processes for all four project areas, chosen a model of bi-directional integration, and are working with the Managed Care Organizations to implement population health management tools like EDie, a web-based technology that provides real time information to reduce ED utilization, improve transitions of care and enhance care coordination. Some of the barriers that were identified from reporting in Quarters 2 and 3 included:

- Provider communication within organizations
- Staff turnover, recruiting barriers (more in rural areas)
- Leadership and clinical staff disagreeing on metrics to track/which are more valuable to track based on clinic location or patient population
- Technology implementation planned for later in the year that will allow for risk stratification, patient rostering, population health management
- Electronic Health Record transitions
- 42 CFR Part 2: sharing information from behavioral health (BH) to primary care physician (PCP) or PCP to BH
- Opportunity to enhance billing workflows that will allow for sustainability

- Internal transitions and/or protocols
- Culture change
- MCO sponsorship for CollectiveMedical
- Staff not working at the 'top of their license'
- Reworking the reporting to make it more relevant to hospitals.

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, selecting and reporting quality metrics, and optimizing their EHRs. 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 were going smoothly, and to determine if any mid-year corrections to the transformation process were 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
- Comprehensive Health Care
- Columbia Basin Health Association

These meetings were extremely productive, and Leadership from these organizations reported 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.

SAR 4 UPDATE: While the majority of primary care sites are making steady progress toward PCMH, two primary barriers exist for the behavioral health providers in successfully implementing population health management tools:

- Having an ONC Certified EHR, and
- Access to the CollectiveMedical Platform

Prior to Integrated Managed Care, behavioral health providers received compensation for services based on a contract with the Greater Columbia Behavioral Health Organization (BHO). Now that the providers are submitting claims to the MCOs for reimbursement, their patient data and claims information has to be collected, stored, and billed through an ONC Certified electronic health records system. Behavioral health providers have been using the incentive funding from the IMC transition to purchase new EHRs, and setting up their EHRs systems. Navigators have assisted fifteen (15) behavioral health organizations transition to new EHRs.

The CollectiveMedical Platform is an admission, discharge, transfer (ADT) notifications system and a care collaboration platform that unifies a patient's entire care team. In the Greater Columbia region, the network includes hospitals, primary and behavioral health care providers, health plans, and even one emergency medical system (EMS), an innovation for this system. Each clinic must be sponsored by a Managed Care Organization, unless it is a primary care practice affiliated with a hospital. Each organization must also complete a "Discovery Form" in order to be added to the CollectiveMedical network. The Discovery Form also requires the upload of a patient eligibility file (patients paneled to the provider organization), which some organizations have had to produce manually, because they are in the process of switching to an ONC Certified EHR.

In order to facilitate access, GCACH staff and the MCOs came together in the Summer of 2019 to develop a workflow to lay out a process for the provider organizations. However, there are a few organizations not yet connected.

Figure 5 demonstrates the workflow for MCO sponsorship to the CollectiveMedical Platform.

MCO Sponsorship to Collective Medical

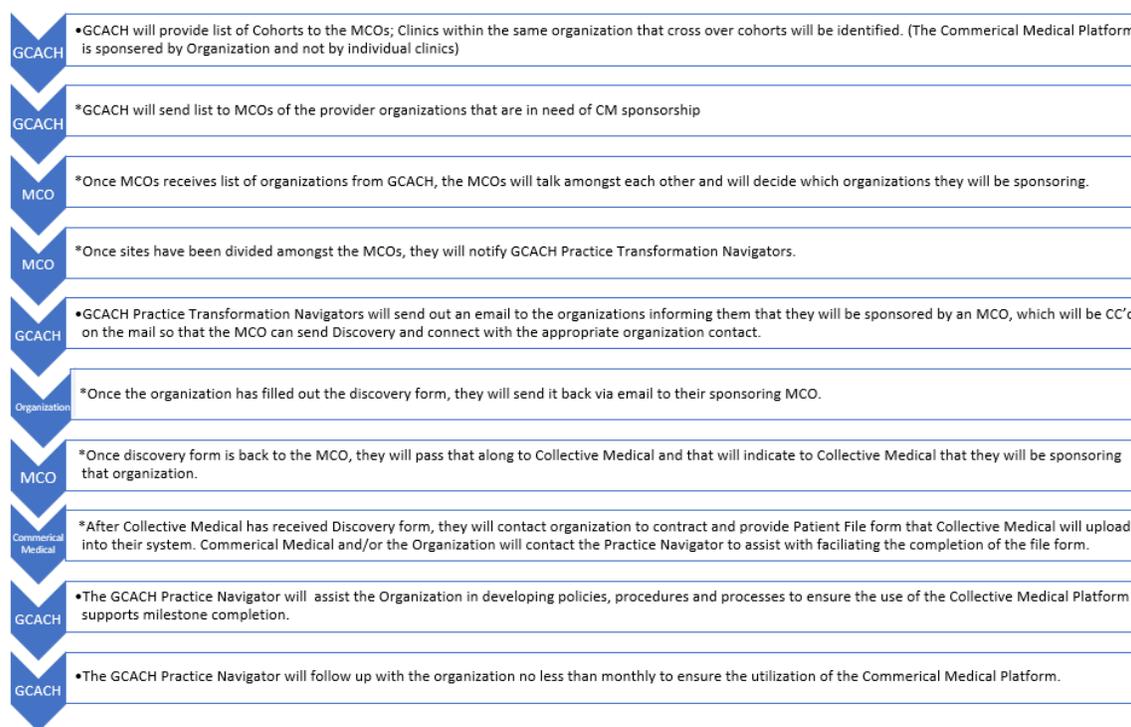


Figure 5; MCO Sponsorship to CollectiveMedical

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 CollectiveMedical 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.

SAR 4 UPDATE: In addition to accessing the CollectiveMedical platform for providers, GCACH staff is exploring a secure texting platform developed by Karuna Health. Karuna integrates with customers' electronic medical record systems and lets users schedule appointments, organize transportation, and repeat messages to patients automatically, such as reminders to take medication.

GCACH is investigating a Community Information Exchange (CIE) called NowPow, and received a demonstration of this product in December. GCACH is also working with the other ACHs to discuss a common strategy in implementing a statewide CIE or, at the least, update electronic community resource directory of social service providers.

The Yakama Nation has a signed contract with Quad+Aim Partners for the Health Commons project, a community health information exchange focused care management of high risk individuals with co-occurring disorders and social service needs. This work is projected to start in January 2020.

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. Figure 6 shows the Scale and Sustain funding model for all three Practice Transformation Cohorts:

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	\$283,598		\$12,761,915					\$12,761,915
Scale and Sustain Allowances (1)	45	\$149,454			\$6,725,430				\$6,725,430
Scale and Sustain Allowances (2)	45	\$74,727				\$3,362,715			\$3,362,715
Subtotal - Cohort 1 Partners			\$0	\$12,761,915	\$6,725,430	\$3,362,715	\$0	\$0	\$22,850,060
Cohort 2 Partners - BHO Partners (JUL-JUN)									
PCMH Transformation Incentives (base)	17	\$247,745	\$0	\$1,899,025	\$2,312,641	\$0	\$0	\$0	\$4,211,666
Scale and Sustain Allowances (1)	17	\$149,454	\$0	\$0	\$1,080,554	\$1,460,164	\$0	\$0	\$2,540,718
Scale and Sustain Allowances (2)	17	\$149,454	\$0	\$0	\$0	\$540,277	\$730,082	\$0	\$1,270,359
Subtotal - Cohort 2 Partners			\$0	\$1,899,025	\$3,393,195	\$2,000,441	\$730,082	\$0	\$8,022,743
Cohort 3 Partners - (JAN-DEC)									
PCMH Transformation Incentives (base)	21	Varies	\$0	\$0	\$6,725,784	\$0	\$0	\$0	\$6,725,784
Scale and Sustain Allowances (1)	21	\$149,454	\$0	\$0	\$0	\$3,129,000	\$0	\$0	\$3,129,000
Scale and Sustain Allowances (2)	21	\$74,727	\$0	\$0	\$0	\$0	\$1,569,267	\$0	\$1,569,267
Subtotal - Cohort 3 Partners			\$0	\$0	\$6,725,784	\$3,129,000	\$1,569,267	\$0	\$11,424,051
Total Incentive Awards - All Cohorts			\$0	\$14,660,940	\$16,844,409	\$8,492,156	\$2,299,349	\$0	\$42,296,854

Figure 6; Cash Flow through 2023

SAR 4 UPDATE: As recorded in Step 1, two provider Cohorts have been added to the Practice Transformation program since June 30, 2019 using the same workbook, toolkit and reporting structure as Cohort 1. The revenue sharing or cash flow model is being updated to reflect the timing of incentive payments, and to reflect the most recent financial projections from the Health Care Authority.

Cohort 3 contracts will be signed by the end of January 2020, and their first reporting period will be in April.

A Component of the Quality Improvement Plan

