	Activity	Steps to Achieve	Progress	Participating Member

	Develop a Data Exchange between AHARO and Health Plan (Payer)	• Finalize Data Agreement for exchanging data between AHARO and Payer with the following objectives:
		  ○ Improve quality of care measures
		  ○ Improve shared accountable care measures
		  ○ Improve HEDIS and Star performance measures
		  ○ Improve access to care
		  ○ Improve patient experience from both Provider and Plan
		  ○ Improve patient care management and coordination
		  ○ Incorporate SDOH into overall patient risk and care management
		  ○ Improve high risk and highest cost utilizers
		  ○ Improve the member enrollment and attribution process
		• The following categories of data should be captured and exchanged between AHARO and Plan: Patient demographics, clinical, utilization, cost, external facilities ADT feeds, social determinants, health outcome, patient experience data, and measures for specific identified populations.
		• Identify underlying data sources:
		  ○ For AHARO Members, typically EPM, EHR, EDR, pharmacy, and ancillary services information systems data, e.g. RIS, LIS.
		  ○ For Payers, typically member/enrollment, claims, risk pool financial data.
		• Develop specific timeline for data exchange.
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		• Develop common platform (with the MSO) for warehousing and exchanging data between AHARO and Payer. • Develop Data Governance to ensure protection and authorization of data access by category of data, staff role and/or other acceptable criteria for both AHAHRO and Payer. • Ensure Data Agreement includes requirements for both AHARO and Plan as outlined in this section, specific deliverables, and performance timeline. • Negotiate and sign Final Data Agreement.		
	Implement data interfaces with other organizations	• Develop ADT feeds directly with hospitals where ADT not available through Health Plans. • Consider and implement interface with HHIE or other health information exchanges.		☐ Bay Clinic ☐ Hamakua ☐ Waianae ☐ Waimanalo
	Rollout Population Management analytics tools	• Leverage common data platform (with the MSO) as a Population Management system to implement the following data analytics features: o Gap analysis o Quality measures reporting o Patient visit planning (huddle) reports o Provider performance dashboards		☐ Bay Clinic ☐ Hamakua ☐ Waianae ☐ Waimanalo
	Utilize Predictive Modeling Program	• Utilize a predictive modeling program based on risk stratification that has the capability to incorporate social determinants of health as follows: o Develop interface from AHARO Member's Practice Management system and EHR to predictive modeling system or leverage common data platform (with the MSO) to interface comparable data.		☐ Bay Clinic ☐ Hamakua ☐ Waianae ☐ Waimanalo

		○ Identify complex and/or high-risk patients and target care coordination efforts. • Lay groundwork for future risk stratification and justification for risk adjustment.		
	Implement Consumer Engagement Tools	• Rollout Patient Portal organization wide with the following features: ○ Patient and family access to PHI (personal health information) ○ Patient and family ROI (Request of Information) ○ Secure communication between patient and provider ○ Patient access to medication refill requests, appointment reminders and requests, medication and allergy lists, visit summaries, and health condition educational materials • To promote Patient Portal access, research and rollout computer/kiosks and/or Wi-Fi access for patients in clinics. • Develop patient surveys utilizing independent third party survey vendor(s), such as Crossroads Group. • Currently the Health Plans assign patients based on geographic proximity (e.g. zip codes) to CHCs. Once the patient is assigned to the CHC, an introductory letter to the patient may currently be the only method by which the patient is notified. Unfortunately, old or outdated patient mailing addresses (obtained from the state) may hinder the ability to the engage the patient. Additionally, patients that are ultimately contacted and scheduled for a PCP visit, may not show up or cancel without notifying the health plan. AHARO proposes developing a pilot project with the Health Plan to improve the patient assignment process and accuracy through the following activities:		☐ Bay Clinic ☐ Hamakua ☐ Waianae ☐ Waimanalo

		○ A three-way call to perform a warm handoff from the Health Plan with the patient on the phone to a care coordinator or other staff at the CHC. ○ A report sent monthly from the CHC to the Health Plan that identifies patients that cannot be contacted by the CHC. ○ A report available to the CHC care coordinators or other staff that provides a status update to initial appointment visits to allow the CHC to follow up with first-time patients. This report can also be sent to the Health Plan. ○ After the initial visit, a follow up call from the CHC to ensure continued engagement and patient satisfaction.		
	Alternative Treatment Models	• Explore EHR integrated telemedicine options, e.g. Certintell's Virtual Visit platform. Develop a pilot project with aim of decreasing unnecessary PPS visits without compromising quality while enhancing patient experience using technology. Any potential savings would be incorporated into resources for HIT/care coordination. • Explore other alternative treatment models, ex. Native Hawaiian healing, group visits, telephone visits, etc..		☐ Bay Clinic ☐ Hamakua ☐ Waianae ☐ Waimanalo
3	Risk Pool Management	• Collaborate with various health plans to identify key drivers of health care costs and develop a plan to reduce them. Key drivers of preventable costs include:: **Managing inpatient care transitions –** Ensure outpatient follow-up within 7 days of hospital discharge for patients with non-obstetric; non-surgical and non-behavioral health primary diagnoses.	**Reduce overall rate of hospital ED usage** – Applies to all Health Center Medicaid patients. Contracts with AlohaCare & HMSA have been signed.	☐ Bay Clinic ☐ Hamakua ☐ Waianae ☐ Waimanalo

		• Receive daily Hospital and ED Admission/Discharge and Transfer (ADT) feeds from the majority of local hospitals. **Decreasing low acuity hospital Emergency Department (ED) usage**- Applies to all Health Center Medicaid patients. • Use of specialized supportive/clinical staff who will contact discharged patients to reconnect them to their medical home and/or schedule an appointment to establish with a provider. **Reducing overall rate of hospital ED usage** – Applies to all Health Center Medicaid patients. • Use of specialized supportive/clinical staff who will contact discharged patients to reconnect them to their medical home and possibly refer high utilizers to case management/care coordination. **Reducing high utilization (6 or more visits) of hospital ED services** – Applies to all Health Center Medicaid patients. **Managing a high risk cohort of non-pregnant adult patients with either diabetes or cardiovascular disease with intensive care coordination by:** • **Addressing their gaps in care** • **Improving medication adherence** • **Managing transitions of care following hospitalizations and ED visits** **Increasing generic Advanced Directives –** Applies to all Health Center Medicaid patients 50 years of age or older. • Finalize contracts with Payers. • Develop means of tracking progress in regards to the key drivers of preventable costs.		

		• Track both clinical and financial performance quarterly		
5	Collect data on Social Determinants of Health (SDOH)	• PRAPARE is a national standardized patient risk assessment protocol going beyond medical acuity to identify risk related to social determinants of health (SDOH). An electronic version of this toolkit has been developed for most commonly used EHR's, including NextGen and Centricity. The toolkit has been modified to include questions more pertinent to the population we serve. While AHARO CHC's may choose to utilize PRAPARE, they may collect SDOH data in whatever manner they choose.	Test week for staff is set for 7/27/15-7/31/15. MA). BH in Adult Med has also been using the tool.	☐ Bay Clinic ☐ Hamakua ☐ Waianae ☐ Waimanalo