BHT Pay for Achievement Measures for Clinical Partners

UPDATES FOR 2021-22 (YEAR 3) CONTRACT PERIOD

Introduction

BHT's Board has approved a Pay-for-Reporting funds flow model for behavioral health and primary care Partnering Providers in 2019, 2020, and 2021. See this link for more information: http://www.betterhealthtogether.org/bold-solutions-content/funds-flow-for-2019-21.

The funds flow model is based on three components:

1) Partners meeting the milestones they specified in their Transformation Plans (40%)
2) Partners meeting a minimum number of Pay-for-Achievement (P4A) measures from a menu provided by BHT (40%)
    - Partnering Providers will continue to work on the four (4) measures selected in their first contract year (2019-2020) and two (2) measures selected in their second contract year (2020-2021), for six (6) total measures
    - Partnering Providers will not select additional measures for the third contract year (2021-2022)
3) Partners meeting organizational milestones for equity (20%)

Pay-for-Achievement Measures

BHT's Pay-for-Achievement measures are intended to recognize Partnering Providers' progress toward transformation. They are conceptually related to many of the statewide Medicaid Transformation pay-for-performance measures, which are part of how the region as a whole earns funds, but are more appropriate for measurement & reporting at the level of Partnering Provider organizations. The menu currently includes 16 P4A measures. BHT reserves the right to add or remove items in future years.

Achievement Thresholds to Earn Funds

This document outlines the achievement threshold that partners must meet in order to earn funds for each P4A measure. Two different thresholds are shown:

- The **First Year threshold** applies if 2020-21 is the *first* contract year in which the Partnering Provider is working on the metric (reminder only – no new measures this contract year)
- The **Second Year threshold** applies if 2020-21 is the *second* contract year in which the Partnering Provider is working on the metric (each provider should have 2 such measures carrying over from their 2020-21 contract into 2021-22)
- The **Third Year threshold** applies if 2020-21 is the *third* contract year in which the Partnering Provider is working on the metric (each provider should have 4 such measures carrying over from their 2019-20 contract into 2020-21 and 2021-22)

Data Collection and Reporting

Partnering providers will report on their selected P4A measures twice/year: first at approximately 6 months into the annual contract period and a second time at 12 months / contract end. Reporting will be accomplished online via a survey platform that allows for example documents to be uploaded. The P4A measures rely on narrative reporting, example documents, and aggregate data only. No individual-level or identifiable data about clients or providers is required to report on the measures in this menu. With one exception described in the table below, BHT's P4A measures will be reported at the level of a Partnering Provider organization, rather than for each clinic or practice location. Please note, however that the *statewide* Medicaid Transformation pay-for-reporting metrics will necessitate some clinic/practice-level reporting.

BHT Menu of Pay for Achievement Measures for behavioral health and primary care Partnering Providers – 2020-21

Measure		**Measure Definition** and additional information	First Year Achievement Threshold	Second Year Achievement Threshold	Third Year Achievement Threshold	Measure may be selected by …

1	Organizational capacity for integration	Partnering Provider's organizational domain score from the MeHAF (Maine Health Access Foundation) survey.
		
		MEASUREMENT/REPORTING DETAILS: Partnering Providers will complete the MeHAF survey twice annually, during required contract reporting.
		
		About the MeHAF:[1]
		• The MeHAF is a self-assessment survey designed to measure levels of primary and behavioral care integration. The survey covers two domains:
		  ▪ A) Integrated services, patient and family centeredness – 11 questions;
		  ▪ B) Practice/organization characteristics – 9 questions.
		• Each question is scored on a scale of 1-10.
		• For this P4A measure, BHT will consider the practice/organizational domain score only. The domain score will be calculated as the average rating across the 9 questions in the domain.
			Partnering Provider's organizational domain score increases by at least 1 point between the beginning and the end of the 12-month contract period.
			
			For Partnering Providers with multiple clinic sites, achievement will be assessed at the organizational level, using the median score across sites.
				Partnering Provider's organizational domain score increases by at least 1 point between the beginning and the end of the 12-month contract period.
				
				For Partnering Providers with multiple clinic sites, achievement will be assessed at the organizational level, using the median score across sites.
					Partnering Provider's organizational domain score increases by at least 3 points from the baseline score from Year 1.
					
					For Partnering Providers with multiple clinic sites, achievement will be assessed at the organizational level, using the median score across sites.
						☑ Primary care partners
						☑ Behavioral health partners

[1] Maine Health Access Foundation (MeHAF) is a self-assessment survey designed to assess levels of primary and behavioral care integration. This is the tool required by HCA for waiver pay-for-reporting purposes. The tool has 21 questions grouped into two domains: 1) integrated services and patient- and family-centeredness; and 2) practice / organization capacity including things like leadership, patient & family input, provider training, etc. See this link for more information: https://www.hca.wa.gov/assets/P4R-physical-behavioral-health-integration-practice-site.pdf

Measure		Measure Definition and additional information	First Year Achievement Threshold	Second Year Achievement Threshold	Third Year Achievement Threshold	Measure may be selected by …
		ADDITIONAL NOTES: ▪ Regardless of whether this P4A measure is selected, ALL behavioral health and primary care Partnering Providers will have to complete the MeHAF survey twice a year as part of HCA's required pay-for-reporting metrics. ▪ This measure must be reported at the clinic/site level to meet HCA specifications				
2	Basic chronic disease and behavioral health screening	Partnering Provider has an active protocol for screening in *each* of these three categories: ▪ Chronic disease (at least 1 condition, e.g. diabetes) ▪ Depression ▪ Substance abuse **MEASUREMENT/REPORTING DETAILS**: 1) List/name the evidence-based screening tool(s) used for each category; 2) Upload protocol(s) or workflow documentation, at least one example per category 3) Report % of eligible Medicaid patients screened in the past 12 months (numerator and denominator) in each category **ADDITIONAL NOTES**: ▪ Note that when reporting the % of eligible patients screened (#3 above), "eligible" should be based on the requirements of the evidence-based screening tool(s) in use and/or the Partnering Provider's own definitions. This measure does not require Partnering Providers to report to BHT using any particular measure specifications	Complete reporting only (all three elements).	Partnering Provider improves the screening rate (increases the % of eligible Medicaid patients screened) that was lowest during the first contract year (2019-20). For example, if a Partnering Provider screened 80% of eligible patients for both depression and a chronic disease in the first period but only screened 45% of eligible patients for substance abuse, the Partnering Provider would be expected to increase the substance abuse	Partnering Provider improves (increases the % of eligible Medicaid patients screened) from Year 2 for at least 2 of the 3 screening categories.	☑ Primary care partners ☑ Behavioral health partners

Measure		Measure Definition and additional information	First Year Achievement Threshold	Second Year Achievement Threshold	Third Year Achievement Threshold	Measure may be selected by …
		(such as NQF 0418 for depression screening). Partnering Providers should report in whatever way matches their protocols and is feasible within their data systems.		screening rate during the second contract period.		
3	Universal[2] screening & follow-up - SDOH	Partnering Provider has protocol for screening for social determinant of health needs (e.g. using PRAPARE[3] or another tool), recording data, and making relevant referrals (if patients desire). MEASUREMENT/REPORTING DETAILS: 1) List/name the SDOH screening tool(s) used; 2) Upload protocol or workflow documentation; 3) Report % of eligible Medicaid patients screened in the past 12 months (numerator and denominator)	Complete reporting only (all three elements).	Partnering Provider increases the proportion (%) of eligible Medicaid patients screened compared to Year 1.	Partnering Provider increases the proportion (%) of eligible Medicaid patients screened compared to Year 2.	☑ Primary care partners ☑ Behavioral health partners
4	Peers and CHWs	Partnering Provider increases availability of Certified Peer Counselors, peer support workers, community health workers, or similar roles (Health Coaches, Doulas, Navigators, etc.) MEASUREMENT/REPORTING DETAILS:: 1) Current FTE for each relevant category of worker; and 2) Total number of Medicaid patients served in past 12 months by peer support workers, community health workers, or similar roles (Health Coaches, Doulas, Navigators, etc.) ADDITIONAL NOTES:	Complete reporting only.	Partnering Provider increases the total number of unique Medicaid patients served by these roles.	Partnering Provider increases the total number of unique Medicaid patients served by these roles from Year 2.	☑ Primary care partners ☑ Behavioral health partners

[2] Universal screening as opposed to screening 'as indicated' or diagnostic screening. This does not imply that ALL clients must be screened.

[3] For reference only, see this link for a PRAPARE Implementation and Action Toolkit: http://www.nachc.org/research-and-data/prapare/toolkit/. This brief from the Institute of Medicine contains recommendations about social and behavioral measures to include in electronic health records: http://nationalacademies.org/hmd/Reports/2014/EHRdomains2.aspx

Measure		Measure Definition and additional information	First Year Achievement Threshold	Second Year Achievement Threshold	Third Year Achievement Threshold	Measure may be selected by …
		▪ Some definitions for peer support workers[4] and community health workers[5] are provided below as informational resources. These are not intended as requirements or limitations.				
5	Medication Assisted Treatment	Partnering Provider increases Medication Assisted Treatment (MAT) services for opioid use disorder. MEASUREMENT/REPORTING DETAILS:: 1) Total provider FTE currently providing MAT to patients of the clinic/organization 2) Total number of Medicaid patients who received MAT in past 12 months With additional text question: How easy is it for your clinic/practice to refer patients receiving MAT to other forms of outpatient SUD treatment (e.g. counseling)?	An increase during the contract period in the number of patients undergoing MAT[6]	An increase during the contract period in the number of patients undergoing MAT compared to Year 1.	An increase during the contract period in the number of patients undergoing MAT compared to Year 2.	☑ Primary care partners ☑ Behavioral health partners
6	Care compacts	Partnering Provider has care compacts (a framework for standardized communication between providers to improve care coordination and transitions)[7] with at least three (3) referral partners, at least one of which must be a social determinant of health partner (not a health care partner)	Three documented current compacts / agreements.	One new documented compact / agreement with a social determinant of health partner.	Documentation of strategic review of care compacts from Year 1 and 2, including review of how partners are or could work together to address	☑ Primary care partners ☑ Behavioral health partners

[4] A peer support worker may be a self-identified consumer of mental health and addiction services who has completed specialized training and passed an examination to be recognized as a 'peer counselor'. Peer support workers draw on their own life experiences to provide support, encouragement, and resources to those with similar experiences. Description modified from WAC 388-877-0200.

[5] A CHW is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusted relationship enables the CHW to serve as a liaison or intermediary between health/social services and the community. Definition is from the American Public Health Association, as adopted in the Washington Community Health Worker Taskforce Recommendations Report, 2016.

[6] BHT will provide guidance on baseline and contract end reporting to Partnering Providers in advance of reporting.

[7] See for example: http://www.cms.org/uploads/PCMH-Primary-Care-Specialty-Care-compact-(10-22-10).pdf

Measure		Measure Definition and additional information	First Year Achievement Threshold	Second Year Achievement Threshold	Third Year Achievement Threshold	Measure may be selected by …
		MEASUREMENT/REPORTING DETAILS: List the 3 referral partners and describe / upload care compacts ADDITIONAL NOTES: ▪ BHT provided examples and key elements of care compacts as part of its 2019 Learning Cohort activities. See those resources here: http://www.betterhealthtogether.org/bold-solutions-content/lc-meeting-materials-mar28 ▪ Note that achievement for this measure does **not** require communication between partners involved in the care compacts to be electronic.		Partnering Provider will also maintain compacts / agreements with partners from First Year.	an equity issue (identification of population, sharing data/outcomes etc.)	
7	Complex care planning	Partnering Provider has established process for proactively identifying and managing individuals in need of complex care[8] MEASUREMENT/REPORTING DETAILS: 1) Describe / upload document describing Partnering Provider's operational definition of at least one "complex care" population 2) Describe / upload ONE protocol / workflow process for identifying and providing care management to an identified complex care group (e.g. the most recently updated protocol) ADDITIONAL NOTES ▪ The workflow / protocol submitted for this measure should not be the same as submitted for #2 or #3, as those aren't specific to a complex care population	At least one definition and protocol / workflow submitted.	Submission of next steps in continuation of complex care planning. This might include training additional staff, increasing adherence to protocol, defining team and/or new roles.	Submission of plans for improvement or expansion of complex care planning from Year 1 and 2. This might include increasing # of complex care patients followed; scaling a workflow or process that is working to additional locations/programs; identification and plans to address an identified	☑ Primary care partners ☑ Behavioral health partners

[8] For example, see conceptual taxonomy for identifying high-need patients from the National Academy of Medicine's 2015-16 work on Effective Care for High-Need Patients: https://nam.edu/wp-content/uploads/2017/06/Effective-Care-for-High-Need-Patients-Key-Points.pdf

Measure		Measure Definition and additional information	First Year Achievement Threshold	Second Year Achievement Threshold	Third Year Achievement Threshold	Measure may be selected by …
					equity gap in existing complex care planning.	
8	Patient Advisory group	Partnering Provider has a Patient & Family Advisory group[9] or similar body / function that contributes to decision-making about ways to improve processes, procedures, care delivery, and outcomes. MEASUREMENT/REPORTING DETAILS: 1) Describe / upload document describing the clinic or organization's Patient & Family Advisory structure; 2) Provide an example of how patient & family input was used to change policy or practice. ADDITIONAL NOTES: ▪ For purposes of this P4A measure, Partnering Providers with multiple clinic locations do not need to have a separate patient & family advisory group for each site. ▪ Conducting patient satisfaction surveys or holding a one-time focus group does **not** meet the intent of this measure.	Patient & Family Advisory group: ▪ Holds at least 3 meetings/year in which patients & family members provide input on specific topic(s); ▪ Has a clear mechanism for communicating feedback and recommendations to leadership in a timely manner.	Same as year 1; no change or additional expectation.	Documentation of least of *one* of the following: 1) Advisory group participates in an equity-focused review or improvement process at organization. 2) Completion of review of process for feedback and communication to leadership, including if advisory group feedback was meaningfully taken into account in decision-making. Have recommendations of feedback from PACs been used to make changes? If not, why not? If so, what difference did it make?	☑ Primary care partners ☑ Behavioral health partners

[9] For example, the National Partnership for Women & Families gave this description to practices participating in the Comprehensive Primary Care Initiative: "A Patient & Family Advisory Council is an established council within a health care practice which meets regularly and consists of patients and family members who receive care at the practice. Select providers, clinicians, office staff, and leadership are also integrated members of the PFAC and work with the patient and family advisors to discuss improvements in care, processes, and experiences. Key to the PFAC is that patients and family caregivers are viewed as respected partners and essential resources to the practice." See: https://innovation.cms.gov/Files/x/cpci-patientfamengresource.pdf.

Measure		**Measure Definition** and additional information	**First Year Achievement Threshold**	**Second Year Achievement Threshold**	**Third Year Achievement Threshold**	**Measure may be selected by …**
					3) Expansion of number of advisory groups to other clinics/locations or patient populations.	
9	Behavioral Health service capacity	Partnering Provider increases provision of mental health and/or SUD services (whether onsite or via tele-medicine) MEASUREMENT/REPORTING DETAILS: 1) Unduplicated number of Medicaid clients seen in the last 12 months who received a mental health service (outpatient service, procedure, or prescription); and 2) Unduplicated number of Medicaid clients seen in the last 12 months who received a substance use disorder service (of any kind; outpatient, inpatient/residential, or MAT) ADDITIONAL NOTES: ▪ For purposes of this achievement measure, BHT intentionally is not providing strict definitions about what counts as an MH or SUD service. The intent is to give Partnering Providers flexibility and to focus on improvement over self, rather than comparisons between providers. In contrast, the Medicaid Transformation mental health and SUD treatment penetration pay-for-performance measures, to which BHT is accountable, do have specific definitions that use service type codes and provider taxonomies.	Complete reporting only.	Partnering Provider increases the number of Medicaid members receiving either MH or SUD services, compared to Year 1.	Partnering Provider increases the number of Medicaid members receiving either MH or SUD services, compared to Year 2.	☑ Primary care partners ☑ Behavioral health partners
10	Project ECHO, tele-medicine, or e-consults	Partnering Provider participates in Project ECHO or other e-consult / learning model, or enhances availability of specialty care via new implementation of telemedicine or e-consults	New or expanded implementation of any *one* of the three items above during the contract	New or expanded implementation of any *one* of the three items above during the contract	New or expanded implementation of *one* of the following: 1) Add a program (e.g.	☑ Primary care partners ☑ Behavioral health partners

Measure		Measure Definition and additional information	First Year Achievement Threshold	Second Year Achievement Threshold	Third Year Achievement Threshold	Measure may be selected by …
		MEASUREMENT/REPORTING DETAILS: Attest to (yes/no) and describe or upload document describing: 1) Clinician or practice team participation in a Project ECHO program; **and/or** 2) New or expanded implementation of telemedicine; **and/or** 3) New or expanded implementation of e-consult **ADDITIONAL NOTES**: ▪ Project ECHO[10] is a case-based tele-mentoring learning model that through videoconferencing connects practicing clinicians with specialist teams (e.g. psychiatrists, hepatologists, addictions medicine, dermatologists, etc.) Participation can enhance the capacity of primary care & behavioral health providers to treat complex illnesses, thereby improving patient access to care. Several ECHO programs are offered through the University of Washington. ▪ Telemedicine consults typically involve a direct provider-to-patient relationship and encounter[11] ▪ E-Consults[12] are an asynchronous, consultative, provider-to-provider communication within a shared electronic health record (EHR) or web-based platform. E-consults are intended to improve access to specialty expertise for patients and providers without the need for a face-to-face visit.	period meets the achievement threshold.	period meets the achievement threshold.	initiate e-consults or ECHO program) to existing tele-medicine work; 2) Maintain participation in ECHO program(s); 3) Maintain access to tele-visits regardless of post-COVID payment policy or reimbursement changes. 4) Add program or component to address equity gap in existing tele-medicine offerings (e.g. offering component for an identified population such as Hispanic agricultural workers or rural patients; establish interpreter services via tele-health)	

[10] For more information, see: https://echo.unm.edu/
[11] For example, see this definition and description: https://www.medicaid.gov/medicaid/benefits/telemed/index.html
[12] For example, see this article: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4561452/pdf/10.1177_1357633X15582108.pdf

Measure		Measure Definition and additional information	First Year Achievement Threshold	Second Year Achievement Threshold	Third Year Achievement Threshold	Measure may be selected by …
11	Identified PCP	MEASUREMENT/REPORTING DETAILS: Survey question - For what % of Medicaid clients/patients seen in the last 12 months do you have a primary care provider[13,14] identified in your records? Report numerator & denominator. ADDITIONAL NOTES: ▪ The goal of this measure is to ensure that Partnering Providers know / have a record of who their patients' primary care providers are. ▪ The measure specifies that a PCP should be recorded for "patients seen in the last 12 months,' in order to make the expectation reasonable; in other words, BHT does not expect the Partnering Provider to have a PCP name on file for clients/patients that the Partnering Provider has not seen in over a year. ▪ The measure is **not** attempting to measure frequency of primary care visits or PCP access. ▪ The listed PCP should be an individual person, not a clinic or an MCO. ▪ PCP and primary care definitions provided in footnotes are informational resources only and not intended as requirements	Partnering Provider has an identified PCP for at least 90% of patients who have had a visit in the last 12 months.	Same as year 1; no change or additional expectation	Same as year 1; no change or additional expectation	❑ Primary care partners ☑ Behavioral health partners
12	Pregnancy intent	Partnering Provider increases the proportion of women of reproductive age women screened for pregnancy intent. MEASUREMENT/REPORTING DETAILS: Survey question - Proportion of women aged 15-44 (inclusive) at risk of unintended pregnancy with a visit in last 12	Complete reporting only	Partnering Provider increases the proportion (%) of eligible women screened number compared to Year 1	Partnering Provider increases the proportion (%) of eligible women screened number compared to Year 2 OR	☑ Primary care partners ❑ Behavioral health partners

[13] For reference, this is the definition of PCP from Washington State 2018 model contracts for MCOs and FIMC: "PCP means a participating provider who has the responsibility for supervising, coordinating, and providing primary health care to Enrollees, initiating referrals for specialist care, and maintaining the continuity of Enrollee care. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Naturopathic physicians, medical residents (under the supervision of a teaching physician), Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by the Contractor." See: https://www.hca.wa.gov/assets/billers-and-providers/model_contract_ahmc.pdf or https://www.hca.wa.gov/assets/billers-and-providers/ipbh_fullyintegratedcare_medicaid.pdf.

[14] For reference, RCW 48.150.010 (8) defines primary care as "routine health care services, including screening, assessment, diagnosis, and treatment for the purpose of promotion of health, and detection and management of disease or injury."

Measure		Measure Definition and additional information	First Year Achievement Threshold	Second Year Achievement Threshold	Third Year Achievement Threshold	Measure may be selected by …
		months who have a documented response to a pregnancy intention screening question that uses closed-ended response categories.[15]			increases proportion of women previously screened who received follow-up or referral to LARC, as appropriate	
13	Fluoride provision in primary care	Partnering Provider increases the proportion of children under age 19 who receive fluoride varnish as prevention for dental caries. MEASUREMENT/REPORTING DETAILS: Proportion of children with a visit in the last 12 months who had topical fluoride varnish applied by a non-dental provider. Report numerator and denominator for two age groups: ▪ 0 – 5 years ▪ 6 – 19 years ADDITIONAL NOTES: ▪ See WA Medicaid Billing Guide for information on when HCA will cover fluoride varnish in a primary care setting[16]	Complete reporting only	Partnering Provider increases the proportion (%) of eligible children who receive topical fluoride varnish compared to Year 1	Partnering Provider increases the proportion (%) of eligible children who receive topical fluoride varnish compared to Year 2	☑ Primary care partners ❑ Behavioral health partners
14	Expanding evidence-based practices	Partnering Provider implements a new evidence-based practice (EBP) or expansion of an existing EBP. MEASUREMENT/REPORTING DETAILS: Describe or upload documents describing: ▪ What EBP practice was implemented/expanded and why (rationale) ▪ Number and % of organization staff trained to offer the EBP ▪ (Optional): Upload protocol / workflow process for the new EBP	Complete reporting only	Implement a new EBP OR expand an existing EBP (such as increasing number/% of staff trained on EBP)	n/a – this measure was not available Year 1	☑ Primary care partners ☑ Behavioral health partners

[15] For example, One Key Question https://powertodecide.org/one-key-question. Another resource is Upstream USA, which has a Washington chapter providing training, technical assistance and coaching to healthcare partners: https://upstream.org/partnerships/washington/.

[16] See Billing Guide dated October 16, 2018: https://www.hca.wa.gov/assets/billers-and-providers/physician-related-serv-bg-20181016.pdf pages 284-286.

Measure		**Measure Definition** and additional information	First Year Achievement Threshold	Second Year Achievement Threshold	Third Year Achievement Threshold	Measure may be selected by …
		ADDITIONAL NOTES: ▪ The evidence-based practice selected for implementation may be any practice that is relevant to the needs of your patient population and likely to improve the quality of care and/or health equity. It may be broad (e.g. adopting trauma-informed approaches across all patient groups and settings) or more narrowly focused (e.g. weight management protocol for obese patients with psoriasis). ▪ You will be asked to submit the selected EBP in advance of contracting for review and approval.[17] ▪ Expansion of an existing EBP can include increasing the number of staff trained, increasing number of services provided according to the EBP, and/or developing a protocol / workflow process for the EBP if one is not currently in place				
15	Care Transitions	**Partnering provider has established a process for following up with patients discharged from facility[18] by phone or in-person home visit within 72 hours.** **MEASUREMENT/REPORTING DETAILS**: Describe or upload documents describing: ▪ % of patients discharged from facility and followed up by phone or in person home visit within 72 hours ▪ The population and types of transitions to which your care transition processes/protocols apply (e.g. transition from inpatient treatment to home for individuals with SMI)[19]	Complete reporting only	An increase from previous year in % of patients who received follow-up within 72 hours of discharge (can include developing or scaling the established process to another facility)	n/a – this measure was not available Year 1	☑ Primary care partners ☑ Behavioral health partners

[17] Many resources are available for finding and implementing EBPs, including those listed below. BHT can also connect Partnering Providers to technical assistance for choosing and implementing EBPs.
- Washington State Institute for Public Policy (WSIPP) Inventory of Evidence-Based Practices (inclusive of evidence-based, research-based, and promising practices): https://www.wsipp.wa.gov/Publications
- SAMHSA Evidence-Based Practices Resource Center: https://www.samhsa.gov/ebp-resource-center
- University of Washington Evidenced-Based Practice Institute: https://www.ebp.institute/about-the-institute

[18] This might include a patient discharged frogreem hospital, inpatient rehab, emergency department, residential setting, or other transitions between two clinical settings or between clinical and home / community settings.

[19] Care transitions tools and resources can be found at https://caretransitions.org/all-tools-and-resources/.

Measure		Measure Definition and additional information	First Year Achievement Threshold	Second Year Achievement Threshold	Third Year Achievement Threshold	Measure may be selected by …
		▪ (Optional): Upload protocol / workflow process that includes what triggers a follow-up contact, a script for the follow-up call/visit and documentation of the encounter.[20]				
16	Payer contracts	Partnering Provider enters into a new commercial or Medicare Advantage contract. MEASUREMENT/REPORTING DETAILS: Describe or upload documents describing: ▪ Attestation that a contract was established ▪ Name of payer with which the contract was established	Complete reporting only	Partnering Provider maintains contract with new payer	n/a – this measure was not available Year 1	☑ Primary care partners ☑ Behavioral health partners

[20] Best practice covers the following 4 components in scripts: 1) Medication – do they have a list, understand the medication(s), and did they pick them up at the pharmacy?; 2) Follow-up appointment- who is doing the follow-up and do they have an appointment?; 3) Health Condition understanding – do they know what their problems are and what they need to do to manage? 4) Red flags – what are the things they should watch for and if they need to be seen or talk with someone, do they know what to do or who to call?