Forestland Network Example

COHORT MANAGEMENT PROGRAM

PLANNING MILESTONES

EXAMPLE

Version 2018.10.02

Forestland Network Example

MILESTONE 1: CLINICAL DESIGN

Date:	9/30/18
VLC:	Heartwood Hospital, Inc.

Instructions: Use this Clinical Design Milestone Tool to submit your Network's approach for review by the CCN Management Team and Clinical Governance Committee. Completed Milestone Tools should be submitted by email to cohorts@carecompassnetwork.org by **5pm on the 15th of the Month. If the 15th falls on a weekend or a holiday, the completed Milestone should be submitted by 5pm the following business day.**

The timeline for review is as follows:

- Clinical Design Milestones received by the 15th of the month will undergo review and possible approval at the end of the following month. There is a six week review window for this Milestone.
- First review: CCN Management Team. Revisions may be requested.
- Second review: Once the CCN Management Team has identified the Milestone elements have been met, the Milestone score card results will be forwarded to the CCN Chief Medical Officer for a pre-clinical review with select members of the Clinical Governance Committee. Questions and/or revisions may be asked at this point.
- Third review: Upon approval by the subset of Clinical Governance Committee members, the milestone will be presented to the full Clinical Governance Committee for review.
- The final date to submit a Clinical Design Milestone is January 15, 2019.

Objective: As part of the Cohort Management Program, CCN Partner Networks are tasked with designing a program of services for their chosen population cohorts in order to make measurable positive impact on population health outcomes. Networks are expected to integrate services among Partners to better coordinate the use of a range of services, including clinical services, care coordination or management, and non-clinical services which impact Cohort members' Social Determinants of Health.

In completing the Clinical Design Milestone, Networks will:

1) Formally and specifically define their chosen Cohort,
2) Specify the intended outcomes and performance goals,
3) Define the core services that are part of the Network's approach program.

Process: The CCN Clinical Governance Committee (CGC) advises the CCN Board of Directors in its oversight of PPS care delivery, care coordination, quality standards, and the quality performance of CCN DSRIP projects. This role extends to the Cohort Management Program. The CGC will provide clinical oversight regarding Partner Network's choice of Cohort by evaluating the inclusion criteria and formal definitions, evaluating the clinical appropriateness and impact of identified core services relative to the

specified intended outcomes and goals. CGC evaluates the appropriateness of non-covered Medicaid services requested for payment in the Active Management Phase.

Review: The CGC will assess each Network's milestone completion material and provide one of the following possible determinations:

- **Accept** – The Clinical Design Milestone is considered complete.
- **Accept with Contingencies** – The CGC has identified areas for minor improvement. The Network should make the recommended changes and submit to CCN for evaluation. CCN Management will deem the Clinical Design Milestone to be complete, provided the recommended changes have been made satisfactorily.
- **Revise and Resubmit** – The CGC has identified areas which need significant improvement or greater specification. The Network should address feedback and resubmit to CCN for re-evaluation by the CGC. CCN will provide support to address CGC feedback.

(1) DEFINE YOUR COHORT

1. Please provide a general description of your cohort:

The cohort will include **diabetic adult males** living in Chenango and Delaware Counties who are high utilizers of the Emergency Department and who have had low or no primary care engagement in the past year.

1A. Inclusion Criteria:
If available, list the **diagnostic criteria for** Cohort **inclusion**, specifying the ICD10-CM codes and names and/or other clinical criteria. Insert rows to the tables if necessary. One ICD10 code per row.
Reminder: Cohorts should be comprised 100% of Medicaid Members.

Resources: https://www.icd10data.com/ICD10CM/Codes
For support with answering this question, please reach out to your Network Facilitator.

	ICD10 – CM Diagnostic Codes	ICD10 – CM Diagnostic Code Description
1.	E08-E13	Diabetes mellitus

1B. Inclusion Criteria
If applicable, list the **utilization criteria or triggering events** for Cohort **inclusion** (if applicable), specifying the types of event(s) and related definitions and coding information (Universal Procedure or Revenue Billing Codes (CPT, ICD10, HCPCS), etc.).

	Utilization Event Description	Encounter Definitions and/or Codes	Encounter Coding System
1.	4 or more ED visits in the last 12 months.	CPT Procedure Codes: 99281-99288	Heartwood Hospital Billing System
2.	1 or less primary care visits in the last 12 months.	CPT Procedure Codes: 99201-99205; 99211-99215	Heartwood Hospital Billing System

1C. If applicable, list other clinical (non-diagnostic) criteria that may result in the patient being included in the Cohort.

1.	Not applicable
1D. If applicable, list demographic characteristics that are part of the criteria for Cohort inclusion.	
	Demographic Characteristics
1.	Males aged 18 and older that live in Chenango and Delaware Counties.
1E. What is the target Cohort size (must be between 50-200 members)?	
100	
1F. Describe the event(s) or change(s) that would trigger a patient to "graduate" or in other words to be removed from the panel and another patient brought on. Link the answer back to your answers to questions 1A, 1B and 1C above.	
The panel will be reviewed monthly for patients who meet all of the following criteria: 1) have increased primary care visits to 2 or more visits in past 12 months, AND 2) has less than 4 ED visits in past 12 months. Those that meet the criteria will be triggered for graduation from the cohort and another patient will be brought on to the panel.	
1G. How long would a typical Cohort Member remain in the Cohort?	
6 months	

(2) DEFINE YOUR GOALS

1H. Describe the Network's goals for maintaining or improving patient/client outcomes among Cohort members, including clinical and non-clinical outcomes. Include multiple Indicators of Success if appropriate. There is no "right" number of goals.

	Goal Description	Indicators of Success
1.	Reduce Avoidable ED Use	Post-Utilization Index improvement
2.	Establish strong primary care provider relationship	Cohort Members see a PCP within one month of joining the panel and at least once every three months until their diabetes is under control
3.	Increase patient self-management of condition	Graduation from Chronic Disease Self-Management Program

1I. Identify the DSRIP High Performance Metric(s) the Network intends to impact. These metrics will be used to award performance improvement incentive funds, based on maintenance or improvement among Cohort members. If a Network selects multiple indicators the indicator best impacting the Medicaid members will be used to determine performance incentive. Indicate Yes or No.

Metric Name	Indicate Yes/No
Adult Access to Preventive Care	Yes
Antidepressant Med Management - Effective Acute Phase	No
Antidepressant Med Management - Effective Continuation Phase	No
Antipsychotic Medication Adherence - Schizophrenia	No
Children's Access to Primary Care	No
Cardiovascular Disease (CVD) Test - CVD and Schizophrenia	No
Diabetes Mellitus (DM) Test - Schizophrenia and DM	No
Diabetes Mellitus (DM) Test - Schizophrenia, Bipolar, Antipsychotic Rx	No

Follow Up after MH Hospitalization – 30 Days	No
Follow Up after MH Hospitalization – 7 Days	No
Follow Up Care for Children with ADHD Rx - Initiation	No
Follow Up Care for Children with ADHD Rx - Continuation	No
Heart Failure Hospitalization Rate (PQI - 8)	No
Non-Use of Primary Care Services	Yes
Potentially Preventable ER Visits	Yes
Potentially Preventable Readmissions	No
PDI 90 – Children's Composite (Avoidable Hospitalizations)	No
PQI 90 - Adult Composite (Avoidable Hospitalizations	No

(3) DEFINE THE CORE SERVICES AND INTERVENTIONS

1J. In this section you will describe the Network's clinical and non-clinical approach to actively manage the chosen Cohort. In the table below, list all partner organizations and the role and activities of each partner.

☐ **REQUIRED: Attach a workflow diagram that maps each of the partners in the Network and their activities. May be hand written.**

Please provide a short summary describing the core services that will be provided to cohort members through the Network (you will describe each partner's role more in depth later).

The Forestland Network will provide wraparound services to cohort members including referrals to specialists both in and out of the Network. Each cohort member will be required to graduate from the Chronic Disease Self Management Program. Heartwood Hospital, Inc. will identify a patient panel based on meeting the above defined clinical criteria, and Network partners will participate in weekly touchpoints for the first three months of the program to establish a workflow between partners and to develop and refine the necessary criteria for referrals. Referrals for services such as transportation to non-clinical services or participation with health coaches will be provided to all cohort members.

Partner Organization	**Core services provided for the cohort**
Heartwood Hospital	Heartwood Hospital's ED Navigator will outreach to each patient on the panel, conduct a CCN Needs Assessment through phone calls, and begin to identify the needs of individual patients. The ED Navigator will then make referrals to appropriate Network partners based on the results of the Needs Assessment.
Broadleaf Health Network	Broadleaf Health Network will conduct the Chronic Disease Self Management Program for the cohort members every two months. As part of this program, Broadleaf will work closely with Deciduous Daffodils to ensure cohort members are able to attend each class session.

	In addition to running the CDSMP, cohort members may be referred to Broadleaf for behavioral health needs, and will receive evaluation and assessment, medication management, ongoing assessment, and appointment reminders.
Canopy Care Specialists	Canopy Care as the primary care provider will make referrals to specialists as the patient's condition indicates. The primary care physician is responsible for managing the overall care of the patient and communicating with the specialist or specialists as needed.
Deciduous Daffodils	For transportation barriers that are not currently funded or covered by Medicaid, Deciduous Daffodils Association, Inc. will provide transportation. Transportation may include trips to CDSMP classes, the grocery store, fitness facility, job training, or other location that would improve the patient's overall ability to improve their health.
Evergreen Enterprises	For Cohort members referred to Evergreen, the Palliative Care team will assess patient needs and diagnose health challenges. Patients qualifying for palliative care services will receive help with a wide range of issues, including pain, depression, anxiety, fatigue, shortness of breath, constipation, nausea, loss of appetite and difficulty sleeping.

How will the interventions listed above help the Network achieve its goals (from question 1H)?
Through this interdisciplinary team of providers, we will wrap care around the cohort members to improve their ability to self- manage their condition, thus reducing their need to visit the emergency department. The services provided in the Network will be closely monitored through Network meetings and cohort members will be tracked by the Network partners for their progress and to ensure effectiveness of the interventions.

How will the Network communicate updates to patients' primary care provider/physician?
The ED Navigator will always reach out to the primary care office where the patient should follow-up and the primary care office will ensure the patient is in contact with a health coach so that their needs can be met in the office, with the attention necessitated by their cohort status. If the patient does not currently have an established relationship with a primary care provider, they will be referred to Canopy Care Specialists.

1L. For Core Services and Interventions which lack a funding source, CCN will consider requests for support provided that the core service has been approved by the CCN Clinical Governance Committee and the funding request is considered to be reasonable.

Complete the table below with the following information:

- List the item or service being requested.
- List the Network Partner(s) which will provide the item or service.
- List the quantity needed to serve the cohort.
- List the total cost for the item or service.
- List the anticipated impact of the unfunded service (justification for the service).

Forestland Network Example

	Item/Service being requested	Network Partner(s) providing service	Anticipated Quantity Needed to Serve the Cohort	Total Cost per Service	Anticipated Impact of Service
1.	Transportation to non-clinical services	Deciduous Daffodils Association, Inc.	1 time per week, for 20 Cohort Members for 20 weeks	$15 per ride x 40 patients x 20 rides each = $12,000	Address economic and social barriers of members to improve self-management of condition.
2.	Health Coaching	Canopy Care Specialists	1 time per week for 6 weeks for 75 patients	75 x 1x/week x 6 weeks x $40/hr = $18,000	Improve self-management of condition and reassess patients' need for Network services.

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MILESTONE 2: NETWORK BUILD

Date:	10/31/18
VLC:	Heartwood Hospital, Inc.

Instructions: Use this Network Build Milestone Tool to submit your Network's approach for review by CCN Management. Completed Milestone Tools should be submitted by email to cohorts@carecompassnetwork.org by **5pm on the First Business Day of each Month** for consideration during that month's review. If the 5th **falls on a weekend or a holiday, the completed Milestone should be submitted by 5pm the following business day.** Milestone tools received after the first business day of the month may be reviewed the following month. Milestone tools are due at the latest on Friday, February 1, 2019 in order for the Network to be able to convert to the Active Management Phase.

Objective: As part of the Cohort Management Program, CCN Partner Networks are tasked with building a Network of Partners who, together, can implement the program of core services defined in the Clinical Design Milestone, which are intended to improve outcomes among Cohort members.

In completing the Network Build Milestone, Networks will complete:

1) Define the Network and meet Network composition requirements
2) Formally establish agreements and funds flow between Network partners
3) Establish Network governance standards and activities

Process: CCN Management provides oversight to Partners' participation in CCN DSRIP programs and initiatives by setting standards for Partner engagement, service delivery, and reporting of project activities. CCN Management will provide oversight over Network activities to ensure compliant use of program funds and will ensure that Partner Networks meet programmatic requirements.

Review: CCN Management will assess each Network's milestone completion material and provide one of the following determinations:

- **Accept** – The Milestone is considered complete.
- **Revise and Resubmit** – The Milestone requires further specification or development before it can be considered complete.

Forestland Network Example

(1) NETWORK COMPOSITION

2A. Network Name
Forestland Network

2B. List the member Partners of the Network. Refer to the Program Overview for definitions.

- Identify the VLC, Tier 1 CBO and Referral Source.
- The referral source can be one of the partners but there must be at least 4 unique Partners which includes the VLC.
- Organizations can participate informally in the Network.
- Partners can be added, at the discretion of the Network, throughout the process.

Name of Partner Organization		Network Role
1.	Heartwood Hospital, Inc.	Value-based Lead Payment Contractor (VLC) & Referral Source
2.	Broadleaf Health Network, Inc.	Behavioral Health practice
3.	Canopy Care Specialists, LLC	Primary care practice
4.	Deciduous Daffodils Association, Inc.	Tier One Community-Based Organization
5.	Evergreen Enterprises, Inc.	Palliative Care

Note: A Partner serving as the Referral Source may also be the VLC, Tier 1 CBO, or another Partner. There must be a minimum of four distinct partners in the Network at all times.

☐ **2C.** Attach with the submission of this form, a Letter of Participation from each Network Partner. Use the Letter of Participation template (CMP Form C). Note: If the VLC already submitted Letters of Participation with their Planning Application, they do not need to resubmit again.

(2) NETWORK AGREEMENTS AND FUNDS FLOW

2D. Provide a list of agreements among Network Partners under the Cohort Management Program, and the partners involved.

For example, list any agreements between the partners and/or between the VLC and partners pertaining to the exchange of patient information between partners or exchange of services for payment. A Business Associate Agreement (BAA) is necessary for any exchange of protected health information (PHI) among Network Partners.

*Exclude agreements that do not pertain to Cohort Management activities. Copies of the agreements do **not** need to be provided.*

General Scope of Agreement(s)	**Partner One**	**Partner Two**	**Status**
Service Agreement (outlines service obligations between parties for services and funds)	Heartwood Hospital, Inc.	Broadleaf Health Network, Inc.	Executed

Reciprocal Business Associate Agreement (BAA)			
Service Agreement (outlines service obligations between parties for services and funds) Reciprocal Business Associate Agreement (BAA)	Heartwood Hospital, Inc.	Canopy Care Specialists, LLC	Executed
Service Agreement (outlines service obligations between parties for services and funds) Reciprocal Business Associate Agreement (BAA)	Heartwood Hospital, Inc.	Deciduous Daffodils Association, Inc.	Executed
Service Agreement (outlines service obligations between parties for services and funds) Reciprocal Business Associate Agreement (BAA)	Heartwood Hospital, Inc.	Evergreen Enterprises, Inc.	Executed
Service Agreement (outlines service obligations between parties for services and funds) Reciprocal Business Associate Agreement (BAA)	Broadleaf Health Network, Inc.	Canopy Care Specialists, LLC	Executed
Service Agreement (outlines service obligations between parties for services and funds) Reciprocal Business Associate Agreement (BAA)	Broadleaf Health Network, Inc.	Deciduous Daffodils Association, Inc.	Executed
Service Agreement (outlines service obligations between parties for services and funds) Reciprocal Business Associate Agreement (BAA)	Broadleaf Health Network, Inc.	Evergreen Enterprises, Inc.	Executed

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Service Agreement (outlines service obligations between parties for services and funds) Reciprocal Business Associate Agreement (BAA)	Canopy Care Specialists, LLC	Deciduous Daffodils Association, Inc.	Executed
Service Agreement (outlines service obligations between parties for services and funds) Reciprocal Business Associate Agreement (BAA)	Canopy Care Specialists, LLC	Evergreen Enterprises, Inc.	Executed
Service Agreement (outlines service obligations between parties for services and funds) Reciprocal Business Associate Agreement (BAA)	Deciduous Daffodils Association, Inc.	Evergreen Enterprises, Inc.	Executed

2E. Provide a brief description and rationale of a funds flow plan for Network Partners, including percentage allocation, frequency, and/or basis for Network Partners' payments during the Cohort Active Management Phase for (1) Needs Assessment, (2) PMPM, (3) Unfunded Services (4) Performance Incentive

Note: CCN has a toolkit which provides examples of different Network funds flow models though Networks can develop a different funds flow model.

Heartwood Hospital, Inc. will be flowing funds for months 0-3 as listed below. This will be re-evaluated at month 3 to consider adjustments based on Network input.

1. Needs Assessment Funds Flow Methodology/Allocation

Heartwood Hospital, Inc. will perform the CCN Needs Assessments and will keep 100% of the funds received for the completed assessments.

2. PMPM Funds Flow Methodology/Allocation

A minimum of 70% of the funds will go to non-VLC partners in the Network. The remaining 30% will be reserved for the VLC to cover administrative costs. Non-VLC partners will receive equal portions of the 70% of PMPM based on the number of partners in the Network.

3. Unfunded Services Funds Flow Methodology/Allocation

Unfunded Services as listed in the Clinical Design Milestone that have been pre-approved by CCN will be remitted by the VLC to the respective service providers as invoices are approved.

4. Performance Incentive Funds Flow Methodology/ Allocation

Performance Incentive Funds will be distributed to Network partners based on the following:

- Heartwood Hospital: 30%
- Non-VLC partners will receive equal portions of the remaining Performance Incentive funds.

(3) NETWORK GOVERNANCE STANDARDS & ACTIVITIES

2F. Please briefly and concisely answer the questions below describing the Network's performance management approach to actively manage the chosen Cohort.

What are the key strategies to ensure the Network can effectively work together?

At each meeting, the Forestland Network will review its process measures. Sessions will focus largely on trends and contributing factors.

How will the Network identify gaps in service?

If the trend is improving, the Network will seek to identify root causes and replicate success. In the event the trend is worsening, the Network will identify gaps in their processes and workflows and revise.

How will the Network integrate service delivery?

During case conferencing, the Network will identify the services each partner has provided to each Cohort member and will identify and troubleshoot any areas where services need to be better integrated.

How will the Network improve outcomes?

The Network will continually monitor data on the indicators of success, and will strategize how to make improvements during each meeting. Through the coordinated effort of each partner, the Network will develop rapid cycle improvement plans to address any areas of concern.

2G. List the core Network activities that are part of the Network's approach to managing the Cohort and the Network Partner(s) who are responsible for the activity during the Active Cohort Phase of the program. **NOTE: These activities are separate and distinct from the service activities each partner will provide individually to patients.**

Forestland Network Example

Examples: Case Conferencing, Service Integration, Assign Resources to Cohort Members, Process Improvement, Identify Performance Gaps, Facilitated Meetings, Tracking Patient Engagement, Tracking Key Indicators (leading, outcomes), Supporting Partner Engagement, Action Planning, Tracking Progress, Partner Report Outs, Sharing Best Practices, Data Sharing, Dashboards, Partner Onboarding, Mentoring, Triumphs and Fails, Identify Existing Patient/Client Relationships, etc.

	Network Activity	Network Partner(s)
1.	Assign Resources to Cohort Members	Heartwood Hospital
2.	Case Conferencing	All partners
3.	Set agenda, Prepare for and Facilitate Weekly Meetings	Evergreen Enterprises, Inc.
4.	Participate in weekly meetings • Data sharing • Identify performance gaps	All partners
5.	Identifying Patient Touchpoints in Network	Canopy Care Specialists, LLC

2H. What are the most important referral pathways to develop or optimize, based on the needs of Cohort and Network performance goals?

The Forestland Network intends to use Heartwood Hospital to refer cohort members to the appropriate resources. Referrals to needed resources would most likely be a Network partner but may not be. In the event that the cohort member needs transportation to their next appointment, the appropriate partner will schedule this with Deciduous Daffodils onsite. In the event the cohort member needs behavioral health support or services, Broadleaf Health Network, Inc. would receive the referral and commit to following up within 24 hours. In the event palliative care was required, the cohort member would be referred to Evergreen Enterprises. If the cohort member did not have a primary care provider they would be referred to Canopy Care Specialists. No referral is exclusive of the other, but would seek to identify complex needs identified during the Needs Assessment.

2I. Describe the Network's approach to avoiding duplication of efforts related to Patient/Client engagement or services. How does the Network ensure multiple Partners are not providing similar services and that the approach is coordinated?

Through weekly Network meetings, the Forestland Network will ensure that each partner organization fulfils a unique role and is not duplicating efforts. For the purposes of the cohort management program, all parties have agreed to commit to the scope of work outlined while relying on the designated Network partner to perform the activities they've committed to in the scope of the Cohort Management Program. In the event that conflicts arise in this area, the Network will use its governance model to address the situation through conflict resolution and/or mediation.

2J. Describe the Network's approach to management and governance. An additional document may be attached.

Network Activity	Description of Approach
How often is it anticipated the Network will meet, where, and who convenes the meetings?	Weekly with Evergreen Enterprises VP Operations convening the members of the Forestland Network

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Describe the Network's approach to assessing the needs of the Cohort, needs of individual Cohort members, and/or which services should be offered to Cohort members.	Cohort members are assigned based on the the criteria outlined in the Clinical Design Milestone. Cohort members will be assessed using the CCN Needs Assessment and referred on this basis. Forestland Network will also use behavioral health and palliative care screenings in order to determine appropriate referrals.
How are decisions made in the Network? (examples: VLC makes decisions, decisions are made by the Network collectively – there are no right or wrong answers)	During weekly meetings, the meeting facilitator will engage the partners to make decisions collectively and receive the buy-in of the Network for decisions that are made.
How will decisions about new Network partners be made once the Network is established?	Members of the Forestland Network will vote on the addition of new members. This might happen if 1) the needs assessment reveals a service gap not currently addressed by the Network or 2) if Network performance is at risk and bringing on a Network partner is beneficial. The members of the Forestland Network will decide if this is feasible given the funds flow structure.
How will performance of Network partners be addressed if performance needs remediation?	Performance of Network partners will be discussed at the monthly meetings. If a Network partner were not meeting its obligations as outlined in its Service Agreement, that will be handled by the VLC and addressed privately.

Forestland Network Example

MILESTONE 3: DATA REPORTING

Date:	11/30/18
VLC:	Heartwood Hospital, Inc.

Instructions: Use this Data Reporting Milestone Tool to submit your Network's approach for review by CCN Management. Completed Milestone Tools should be submitted by email to cohorts@carecompassnetwork.org by **5pm on the First Business Day of each Month** for consideration during that month's review. If the 5th **falls on a weekend or a holiday, the completed Milestone should be submitted by 5pm the following business day.** Milestone tools received after the first business day of the month may be reviewed the following month. Milestone tools are due at the latest on Friday, February 1, 2019.

Objective: As part of the Cohort Management Program, CCN Partner Networks are tasked with designing a program of services for their chosen population cohorts in order to make measurable positive impact on population health outcomes. Networks must also track their progress relative to their goals and ensure that services provided by the various Network Partners are well coordinated. Doing so requires a well-developed data reporting and sharing approach that will support Networks in their mission to drive progress and improve health outcomes for Cohort Members.

In completing the Data Reporting Milestone, Networks will:

1) Identify indicators and methods for gathering data
2) Establish processes to share and act on data

Process: CCN Management provides oversight to Partners' participation in DSRIP Projects by setting standards for Partner engagement, service delivery, and reporting of project activities. CCN Management will provide oversight over Network activities to ensure compliant use of program funds and will ensure that Partner Networks meet programmatic requirements.

Review: CCN Management will assess each Network's milestone completion material and provide one of the following determinations:

- **Accept** – The Milestone is considered complete.
  Revise and Resubmit – The Milestone require further specification or development before it can be considered complete.

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(1) GATHERING DATA

3A. Describe the Network's goals for improving patient/client outcomes among Cohort members, including clinical and non-clinical outcomes. This information is also included in the Clinical Design Milestone tool. Include multiple Indicators of Success for each Goal if appropriate.

Goal Description		Indicators of Success
1.	Reduce Avoidable ED Use	% reduction of avoidable ED usage for the cohort
2.	Establish strong primary care provider relationship	Cohort Members see a PCP within one month of joining a primary care practice or being reactivated with their primary care provider, and at least once every three months until their diabetes is under control
3.	Increase patient self-management of condition	Graduation from Chronic Disease Self-Management Program

3B. Describe how the Network will track each Indicator of Success for the Cohort by completing each field in the table below for each Measure or Data Element.

Indicators of Success		Measures or Data Elements	Data Source and System	Level of Tracking (Individual, Aggregate, or Both)	Frequency of Assessment	Notes/Comments
1.	Reduce Avoidable ED Use	ED Visits (avoidable)	Heartwood Hospital, Inc. System; 3M Criteria	Individual Cohort Members; Aggregate Performance	Monthly	
2.	Increased Primary Care Use	Primary Care Visits After ED Visit	Heartwood Hospital, Inc. and Canopy Care Specialists, LLC Systems	Both	Monthly	This will be measured in terms of frequency and time between ED visit and PCP visit to determine whether or not follow-up is a critical factor and at what point.
3.	Increase patient self-management of condition	Patient scores on post-test improve	Canopy Care Specialists, LLC System	Both	Monthly	This will be measured through pre and post assessments by Canopy Care Specialists

☐ **3C.** Provide a sample?report(s) with populated results reflecting the initial Cohort population membership that will be used to track the measures and data elements identified above.

Note: Reports containing **Protected Health Information (PHI)** should be communicated to CCN using the CCN sFTP site. Please communicate with your assigned CCN Network Facilitator regarding this submission.

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3D. Describe the requirements and processes the Network has established to track Cohort Member Engagement with individual Network Partners for services. Attach any tracking tools your Network uses, if appropriate.
Note: During Active Management of the Cohort, CCN will not be collecting this information, but it is important that the Networks track Cohort Member Engagement.

	Cohort Member Tracking Requirements and Processes	Responsible Partners	Frequency of Assessment
1.	Track all ED Visits using our local RHIO	Heartwood Hospital, Inc	Weekly/Monthly
2.	Track PCP Visits	Canopy Care Specialists, LLC	Monthly
3.	Behavioral Health Consultations	Broadleaf Health Network, Inc.	Weekly/Monthly
4.	Palliative Care Services Provided	Evergreen Enterprises, Inc.	Weekly/Monthly
5.	Care Management Interactions x Type	Heartwood Hospital, Inc.	Weekly/Monthly
6.	Transportation Services for Cohort Members	Deciduous Daffodils Association, Inc.	Weekly/Monthly
7.	Referrals Made x Type	All partners	Weekly/Monthly

(2) SHARING AND ACTING ON DATA

3E. Describe the requirements and processes the Network has established to share data among Network Partners to better coordinate and enhance services provided to Cohort Members, including engagement in services by Cohort Members among various Network Partner (as tracked by Network Partners).

	Data Sharing Requirements and Processes	Responsible Partners	Frequency of Assessment
1.	Share patient encounters with Network	All	Monthly
2.	Assign primary responsible Partner for patient outreach	Canopy Care Specialists, LLC	Monthly

3F. Describe how the Network uses reports to do the following:

Determine which services or Partners should be deployed to address the needs of a particular Cohort Member

The Network will review the number of ED visits for each patient and for those that are increasing, direct outreach will be assigned to the ED Navigator. PCP visits will also be monitored and for those not making their appointments, the PCP office will do outreach.

Identify gaps in performance, barriers, or other areas which need to be addressed

Evergreen Enterprises will facilitate Network meetings to drive towards meeting Network goals, using principles of Continuous Quality Improvement.