Required Public Disclosure for Waivers of the Fraud and Abuse Laws

To promote the purposes of the Medicare Shared Savings Program and advance the clinical integration efforts of The Queen's MSSP ACO, LLC. As of July 1, 2019, the Board of Directors has approved and authorizes the provision of the following programs and services for all ACO participants.

Information Technology and Related Services Arrangement:

- Enterprise Data Warehouse. A population health IT platform allows for data integration and analytics that provide tools for providers to empanel and risk stratify patients, identify complex care populations to address special care needs, develop actionable registries for population management, and systematically assess patients' psychosocial needs and inventory resources and support to meet those needs. Clinical data exchange allows for the sharing of clinical information to create integration and coordination of care-delivery across the continuum of care.

- Hawaii Health Information Exchange (HHIE). HHIE is an electronic health information exchange across multiple platforms that allows health care providers, health plans, clinics and hospitals to contribute and access complete health information. HHIE is the State's designated entity for health data exchange.

- TigerConnect. A secure, HIPAA compliant, text messaging application which enables providers to electronically capture the following care plan elements: advance directives and preferences for care; patient health concerns; goals and self-management plans; actions plans for specific conditions; interventions and health status evaluations and outcomes; identified care gaps.

Clinical Programs and Services Arrangement:

- Care Management Services. Care Management Services are available to ACO participants to improve quality of care and lower the total cost of care. Care Management services are provided by Queen's Clinically Integrated Physician Network (QCIPN) staff. Services include High Risk Care Management which is tailored to support providers in meeting the needs of complex patients and includes clinical support, resource coordination and patient education; and the Transitional Case Management Program which supports high risk needs patients from the acute care setting to the next level of care.

- Integrated Behavioral Health – Collaborative Care Model. A mental health integration program which provides consultative psychiatric services via the University of Washington's Collaborative Care Model. The service support prescribing provider in developing medication and behavioral health treatment plans. The services are provided by the QCIPN staff which is composed of contract psychiatrists, mental health social workers and support staff.

- Integrated Behavioral Health – Collaborative Care Model for Skilled Nursing and Long Term Care Facilities. Provides consultative psychiatric and care coordination support to improve access and quality of behavioral health care for patients. And aims to increase the competency level of staff/providers in SNF/LTC facilities via educational & case based learning. The SNF/LTC facilities involved in this program are ACO Affiliate Participants: Chinese Palolo Homes, Avalon (Hale Nani / Kalakaua Gardens) and Aloha Nursing.

- Advanced Care Planning Clinic. ACO sponsors through QCIPN staff a group ACP clinic with a palliative care RN facilitator and offers a home-based ACP program that includes a palliative care RN/LSW. Facilitates the appropriate completion and community distribution of advanced care planning forms to assure that patients' wishes will be honored.

- ACP Decisions - Advanced Care Planning Videos & Resources. ACO Providers have access to over 200 ACP Decision videos in 20 languages. These shared-decision making tools offer patients and families education videos that accurately portray the medical conditions they face, explain their treatment options, and help them partner with their providers to plan for future medical care.

- Integrated Diabetes Management Program. This program is a multidisciplinary collaboration to improve access to limited endocrinology resources, promote diabetes health and wellness, and support providers in meeting the needs of their high-risk patients with diabetes. This program seeks to support treating providers in a patient-centered, integrated model of care, that includes: endocrinology consultation, disease specific education, medical management, behavioral health support and navigation.

- Integrated Comprehensive Medication Management. Creates an integrated pharmacy model to support tour primary care providers in providing comprehensive medication management for the highest risk, highest needs patients. A pharmacist is integrated into the care team to provide medication reconciliation for chronic conditions; a social worker will visit the patient to match prescribed medication to what is actually taken and serve as the coordinator between patient, PCP, specialist and pharmacist

- Community Palliative Care: Advanced Illness Management. This model was developed with Bristol Hospice and works to provide patients with advanced illness access to palliative care in the community. PCPs work with a multidisciplinary extended care team including RNs, social workers, chaplains, pharmacists, dieticians and care aides. QCIPN Clinical Care Team helps to assess and refer appropriate patients with guidance form the PCP, geriatrics/palliative care teams to insure the most appropriate level of care.

- Integrated Medical Nutrition Program. Creates a system of multidisciplinary collaboration to improve access to registered dietitian nutritionists (RDN) resources, promote nutrition health and wellness, and support providers in meeting the needs of our high risk patients in a team-based model of care. This program seeks to support the treating provider in a patient-centered, integrated, model of nutritional care that includes:

validated nutritional screening and assessment of the community residing older at-risk adult, medical nutrition therapy consultation, disease specific nutritional education, behavioral health support, care coordination, community partnership with food programs, and navigation.[1]

Quality Improvement Related Arrangements

- Quality Improvement Support. The QCIPN Practice Transformation and Quality Improvement team includes a team of QPAs (Quality Practice Assistants) that can help ACO Participating Practices adapt and transform from Fee-For-Service (FFS) to Fee-For-Value (FFV). The team aims to help practices adopt team-based care, streamline processes, and create efficiencies.

- Practice Assessment. QCIPN team works with member practices to assess workflows, analyze EMR data entry & coding, review financial and referral processes, and identify care gaps, inconsistencies, and inefficiencies, as well as help to develop care plans to correct areas of need.

- Educational Programs and CME. The ACO will provide educational opportunities for it's Participating Providers including: Schwartz Rounds, Town Hall Meetings, Grand Rounds and other programs for qualifying CME credits including Education Webinars, Events and Conferences. The Queen's MSSP ACO held an Educational Conference on July 20, 2019.

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[1] The Integrated Medical Nutrition Program was approved by the Queen's MSSP ACO, LLC's Board of Directors on July 17, 2019.