**Community Health Accountable Care (CHAC)**

**Clinical Programs—Supplemental**

In addition to the information shared in Appendix D of the Green Mountain Care Board’s ACO filings request, CHAC’s Medicare Shared Savings Program activities include several other priorities and activities.

CHAC will continue to foster stronger primary care collaborations with behavioral and home health to be expanded for better patient coordination. On a local level, many of these relationships exist and best practices are shared through centralized CHAC Clinical Committee activities. In the coming months, however, CHAC plans to identify and expand network-level strategies that enhance patient care and care coordination.

CHAC has identified as a priority a focus on providing screening for social determinants of health as a part of overall care planning for patients. Specifically, CHAC is piloting the Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE), a national effort to help health centers and other providers collect the data needed to better understand and act on their patients’ social determinants of health. The PRAPARE tool utilizes a common screening tool that can be integrated into an electronic health record. CHAC is piloting the use of this tool and plans to expand its use over time. More information about PRAPARE and its screening domains can be found here : <http://www.nachc.org/research-and-data/prapare/>

CHAC has developed common clinical guidelines in five areas (noted below, and complete clinical guidelines included).

1. COPD Treatment and Prevention of Readmission
2. Fall Risk Management
3. Congestive Heart Failure (CHF) Treatment and Prevention of Readmission
4. Depression Care Screening and Follow-Up
5. Diabetes

These clinical guidelines were developed through extensive collaboration of CHAC participants and are being used across the network to better standardize care strategies and monitor clinical outcomes for the affected patient populations. CHAC’s Clinical Committee is currently evaluating the development of additional guidelines in several other areas.

Additional activities that CHAC has planned that will support its clinical priorities include:

* Continued utilization of PatientPing hospitalization alert system
* Additional planning to connect CHAC providers connected with HIE capability
* Expand best practices strategies taking place at the individual CHAC participants (home visits, telehealth, discharge planning, and chronic disease management)