

The Practice Transformation Support Hub

Technical Assistance Update & Trends

Rick Helms, MSW
Practice Transformation Support Hub
Qualis Health
rickh@qualishealth.org





The Healthier Washington Practice Transformation Support Hub

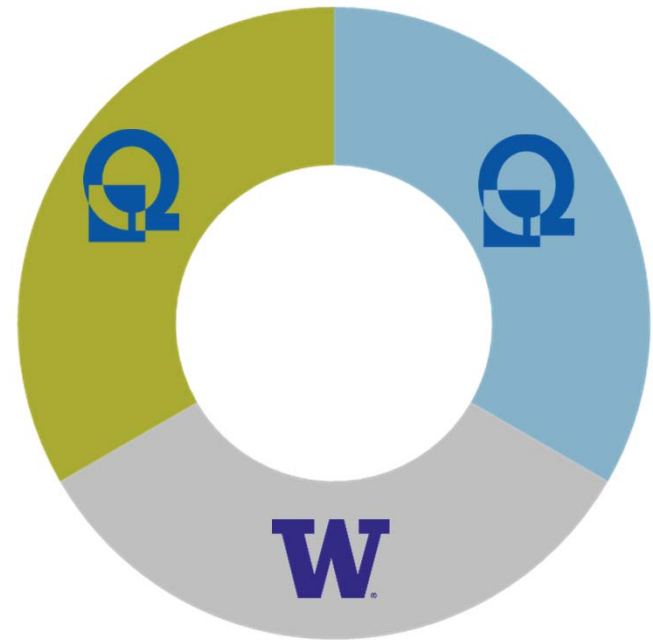
- An investment of Healthier Washington managed by the Washington State Department of Health
- Helps practices successfully move to whole-person, patient-centered care





The Hub: A Four-year, State Innovation Model (SIM) Testing Grant

- Three separate contracts, funded by DOH
- Qualis Health provides Practice Coaches and Regional Connectors programs
- Web Resource Portal offered through partnership with UW Department of Family Medicine Primary Care Innovation Lab

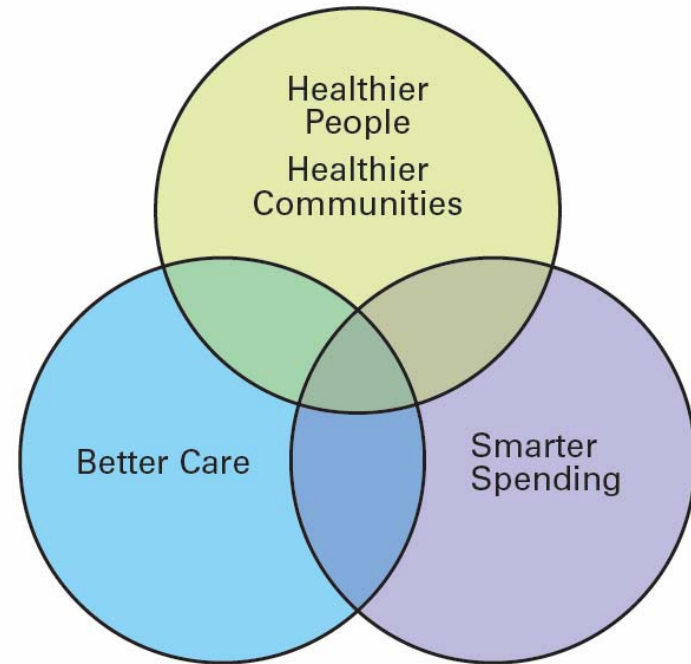




Hub Goals

Help Providers to:

- Integrate physical and behavioral health
- Move from volume-based to value-based care
- Improve population health through clinical and community linkages



To achieve the Triple Aim



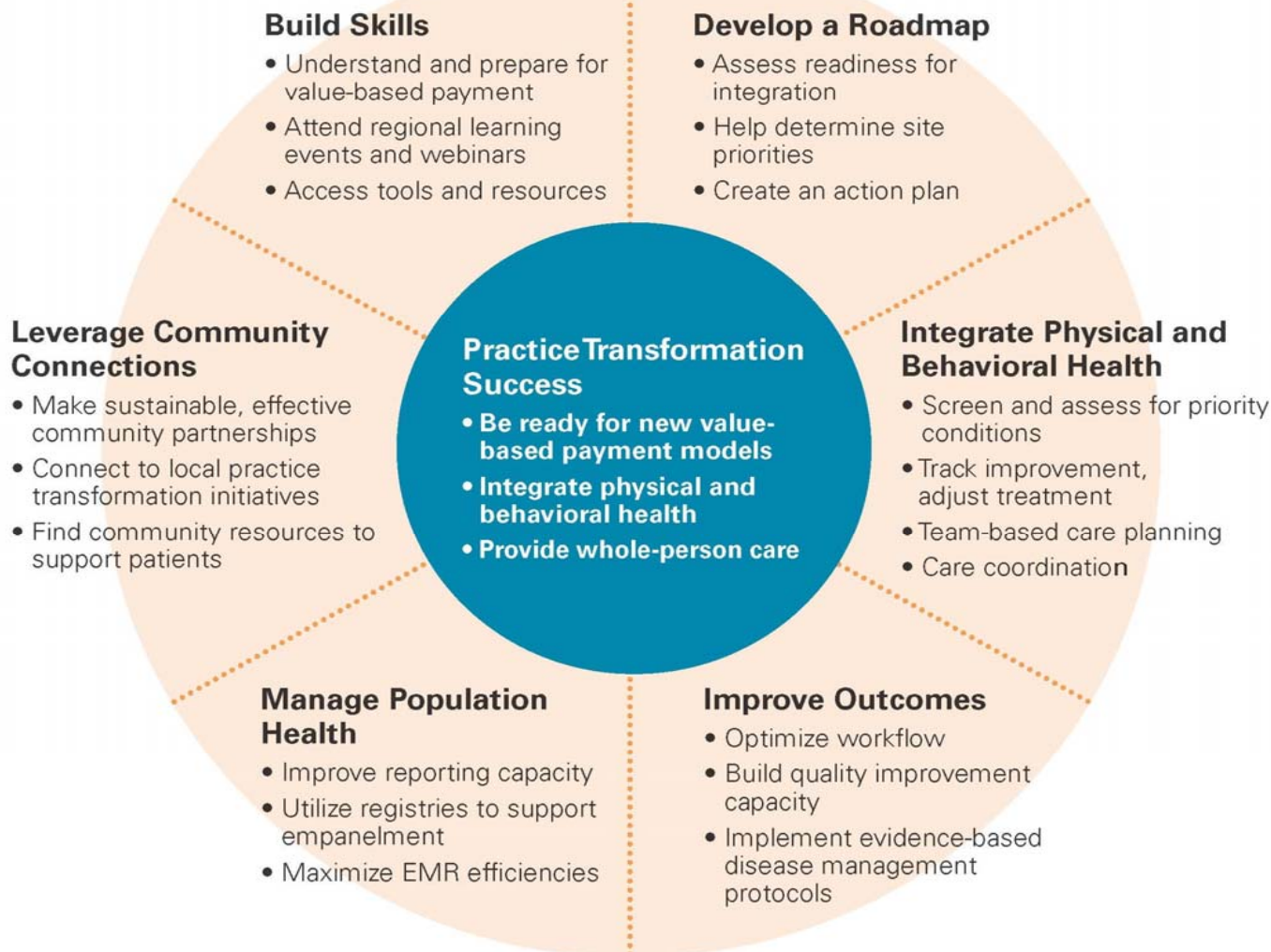
The Change Process

Practice transformation involves changes to both clinical services and operations, and there is a lot to do, but practices can break down each change to a series of action steps:





The Hub can help you:



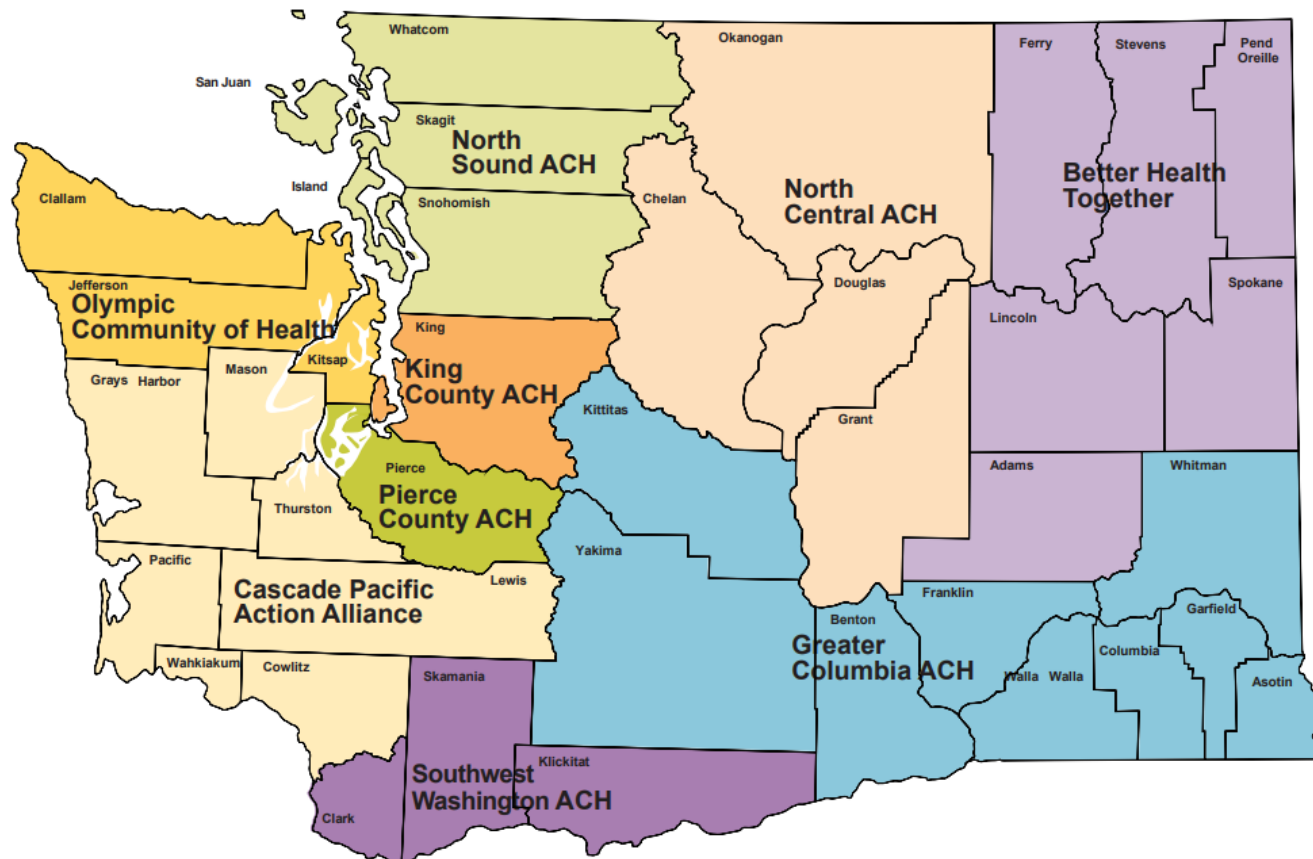


Where do we start?



Where do we start?

ACH Regions Map





Who's out there to help?



Overview of Free Practice Transformation Support Available in Washington State

There are a variety of programs offering free practice transformation resources and technical assistance to practices. There are participation exclusions for some programs, but not all. Find out more in the table below. More detailed information is available on the Hub's Resource Portal at <http://www.waportal.org/resources/practice-transformation-directory>.

| Initiative/Program | What Does the Program Do? | Who is Eligible? | What Services Are Provided? |
|---|--|---|--|
| Department of Health Transforming Pediatric Practice (TCPI); Ends 9/2019 Contact: Melissa Thoemke melissa.thoemke@doh.wa.gov Website: pediatrictcp.org | Assistance to improve health outcomes for children on Medicaid and Children's Health Insurance program. | Pediatric primary care and behavioral health providers and practices with an emphasis on rural and underserved areas. Ages 0-21 Medicaid payer. | Regionally based on-site practice facilitators assist clinicians with integrating quality and process improvements to provide evidence-based, efficient patient-centered care. |
| National Rural Accountable Care Consortium (TCPI); Ends 9/2019 Contact: Robin Moody rmoody@nationalruralaco.com Website: nationalruralaco.com | Assistance to develop a sustainable care coordination and population health management program that will improve health and reduce costs and allow practices to participate in value-based payment models. | Rural and community primary care and specialty providers. All populations. | Remote technical assistance; project planning and curriculum. Monthly calls, training, live workshops. Library of on-demand training offers flexible learning. |
| PeaceHealth (TCPI); Ends 9/2019 Contact: Eric Blake EBlake@peacehealth.org Website: www.peacehealth.org/phma/home | Assistance to PeaceHealth employed clinicians through implementation of team-based care models within the practices. | Washington PeaceHealth affiliated practices. | Resources, tools and practice facilitation to support assessments and capabilities. Leadership development, learning, and practice support. |
| UW WWAMI (TCPI); Ends 9/2019 Contact: BrieAna White briecana@uw.edu Website: depts.washington.edu/uwmedpoint | Assistance to improve population health outcomes, reduce hospitalizations and overutilization of other services. | Primary care, specialty care, all populations. | Technical assistance and connection to resources such as toolkits on best practices. Assistance with the development of plans for transformation. |
| Healthier Washington Practice Transformation Support Hub; Ends 1/2019 Contact: Hub Help Desk 1 (800) 949-7536 ext. 2540 HubHelpDesk@qualishealth.org Website: waportal.org | Assistance to healthcare practices and behavioral health providers for bi-directional integration of physical and behavioral health services. | Priority given to small to medium behavioral health and primary care practices. All payers. | Technical assistance and resources for behavioral health integration, value-based payment preparation. On-site practice assistance, learning events, and a web-based portal on best practices. |



Revised 8-10-17

<http://www.waportal.org/resources/overview-free-practice-transformation-support-washington-state>





Where do we start?



www.waportal.org





PreManage Implementation Toolkit:

A Guide for Washington State Behavioral Health Agencies



Billing and Information Technology:

A Toolkit for Behavioral Health Agencies

January 2018



The project described was supported by Funding Opportunity Number CMS-103-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

<http://www.waportal.org/resources/billing-and-information-technology-toolkit-behavioral-health-agencies>
<http://www.waportal.org/resources/premanage-implementation-toolkit-guide-washington-state-behavioral-health-agencies>





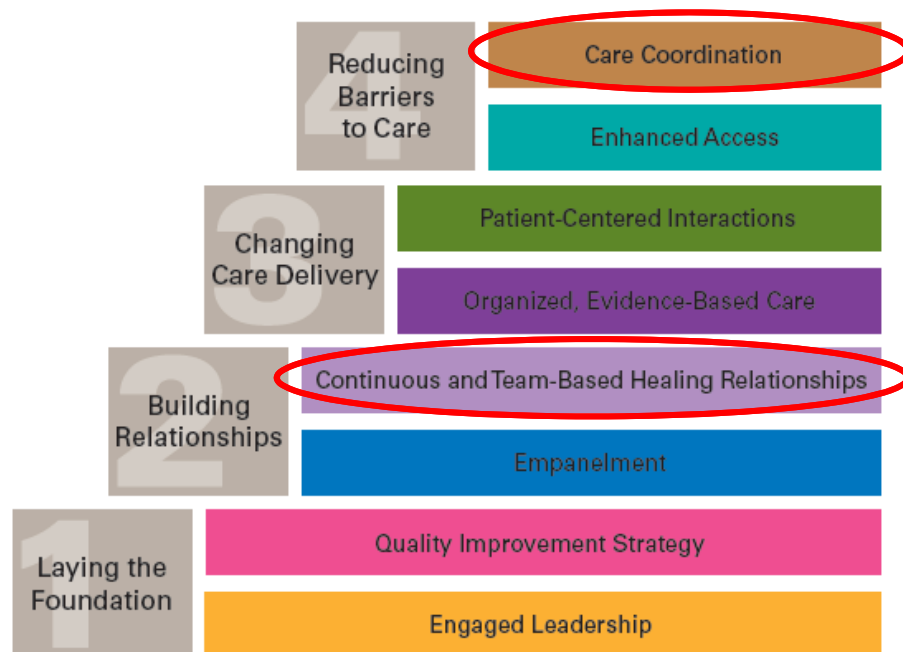
Where do we start?

- Practice Assessment
 - Patient Centered Medical Home Assessment (PCMH-A)
<http://www.safetynetmedicalhome.org/sites/default/files/PCMH-A.pdf>
 - Maine Health Access Foundation Site Self Assessment (MeHAF)
http://www.integration.samhsa.gov/MeHAF_Site_self_assessment_tool.pdf





Where do we start?



For more information, see the

[Organized, Evidence-Based Care Supplement: Behavioral Health Integration Implementation Guide](#)

Whether a primary care practice is just beginning the PCMH journey or is an established medical home, integrating behavioral health care is a critical effort, necessary for true transformation. The goal of integrating behavioral health care in primary care is to provide better access, better outcomes, and a better experience for patients, families, and caregivers—and also to improve the efficiency and operations of the primary care practice itself.

What

What is behavioral health care?

Behavioral health care covers a wide range of patient needs. It can address common social concerns or health behaviors; treat mental health or substance use conditions frequently observed in primary care such as depression, anxiety, or problem drinking; or address more complex disorders such as bipolar disorder or prescription opioid misuse. As a primary care practice begins to consider integrated care, it will be important for it to clearly establish its own definition of behavioral health and its own scope of behavioral health care.

What is integrated care?

There are many different models and approaches to integrated care. What differentiates an integrated care team from a typical primary care team is the relationship between medical and behavioral health providers and the addition of specific functions into primary care.

- Low degree of integration. On-site mental health providers see referred patients for medication management and/or behavioral health specialist visits. The care provided by the behavioral health specialists is largely independent of the primary care providers, although the co-located providers may consult with each other.
- High degree of integration. The primary care team and behavioral health team form one "integrated care team" and actively partner together to share accountability for the total health care needs and outcomes of a panel of patients. They work together from a shared workflow to provide the majority of mental health care in the primary care setting, including medication management and brief behavioral therapies. For patients needing more intensive treatment, there is the option to refer to specialty mental health or substance abuse services, but the integrated care team coordinates that care.

The evidence of effectiveness for integrated care is strongest among models that have a high degree of integration, such as the [Collaborative Care Model](#).

Whatever model or approach the practice selects, the ultimate goal is the same: to develop processes and systems to identify patients that need behavioral health care and monitor those patients to ensure their treatments are effective and are having the desired effect (e.g., reduced depression symptoms).


<http://www.safetynetmedicalhome.org/>









Where do we start?

Quality Measures Crosswalk
An Overview of Corresponding Washington State and Centers for Medicare & Medicaid Services (CMS) Quality Payment Program Initiatives (QPP)



Created by Qualis Health and the Healthier Washington Practice Transformation Support Hub

The project described was supported by Funding Opportunity Number CMS-101-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

| Measure Name | Measure Number | Measure Description | WA State Medicaid Transformation Project Demonstration | | HCA 2017 Apple Health Contract Metrics Medicaid | Quality Payment Program A1 Paper or Medicare Part B (depending on data submission methodology) |
|---|---------------------------|---|--|---|---|--|
| | | | Project Metrics Medicaid | Statewide Accountability Metrics Medicaid | | |
| Comprehensive Diabetes Care: Eye Exam (Retinal Performed) | NQF 0059 QPP Quality #117 | The percentage of individuals 18-75 years of age with diabetes type 1 and type 2 who had an HbA1c test during the measurement year or the year prior | Yes | | | Yes |
| Comprehensive Diabetes Care: Hemoglobin A1C (HbA1c) (Not Control) (at 9%) | NQF 0059 QPP Quality #001 | Percentage of patients 18-75 years of age with diabetes whose most recent hemoglobin A1c level during the measurement year was greater than 9% (not control) | | Yes | Yes | Yes (Outcome Measure) High Priority Measure |
| Comprehensive Diabetes Care: Medical Attention for Nephropathy | NQF 0062 QPP Quality #119 | The percentage of individuals 18-75 years of age with diabetes type 1 and type 2 who received a nephropathy screening or monitoring test or had evidence of nephropathy during the measurement year or the year prior | Yes | | | Yes |
| Comprehensive Diabetes Care: Blood Pressure Control | NQF 0061 | The percentage of individuals 18-75 years of age with diabetes type 1 and type 2 whose most recent blood pressure (BP) reading is < 180/90 mm Hg | | Yes | Yes | |
| Controlling High Blood Pressure | NQF 0018 QPP Quality #236 | The percentage of individuals 18-49 years of age who had a diagnosis of hypertension (I70) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year | | Yes | Yes | Yes (Outcome Measure) High Priority Measure |
| Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life | NQF 1516 | The percentage of Medicaid-enrolled children 3-6 years of age who had one or more well-child visits with a primary care provider during the measurement year | Yes | Yes | Yes | |

<http://www.waportal.org/resources/qpp-quality-measures-crosswalk-2018>



How do we solve workforce issues?



Who else is doing this work?

PRACTICE TRANSFORMATION SUPPORT HUB

WHOLE PERSON CARE AT SEATTLE INDIAN HEALTH BOARD CASE EXAMPLE

SEPTEMBER 2017

About Seattle Indian Health Board

The Seattle Indian Health Board (SIHB) is a private, non-profit organization incorporated in the State of Washington and located in the International District of Seattle. They provide community health care and services targeting the urban American Indian and Alaska Native population in the greater Seattle/King County area, and have been serving this community since 1970.



Services are provided on a sliding fee scale. Although the Seattle Indian Health Board aims to improve the health and well-being of American Indian/Alaska Native people, their services are open to all.

What Whole Person Care Looks Like

In early 2016, Seattle Indian Health Board (SIHB) engaged a behavioral health specialist, and embedded him in the primary care clinic. The behavioral health specialist is available to SIHB clients at any point of service entry such as dental care, diabetes management, veterans' family care, domestic violence. Clients are given a health history when enrolling in any of SIHB's programs, regardless of the type of service. The behavioral health specialist provides screening, assessment, brief counseling, and can make referrals to a variety of other services including chemical dependency, mental health counseling, and Traditional Indian Medicine. Within the health history, a Screening, Brief Intervention, and Referral to Treatment (SBIRT) pre-screen was created that includes the PHQ-2, GAD-2 and additional questions related to mood, trauma, and safety. If needed, the behavioral health specialist can conduct more in-depth screening, using tools like those included in the SBIRT, trauma screens, and other mood assessments. Having a dedicated behavioral health specialist allows the client to be assessed for behavioral

health needs and address those needs at the time of the visit, rather than delaying for a later appointment. Seattle Indian Health Board employs two mental health counselors and recently hired a new, American Indian behavioral health director to oversee their behavioral health services.

“Having a dedicated behavioral health specialist allows the client to be assessed for behavioral health needs and address those needs at the time of the visit.”

PRACTICE TRANSFORMATION SUPPORT HUB

COMMUNITY HEALTH OF CENTRAL WASHINGTON CASE EXAMPLE

AUGUST 2017

About Community Health of Central Washington

Community Health of Central Washington (CHCW) is a federally qualified health center with five primary care clinics located throughout central Washington state. CHCW also operates a dental clinic, and a SRCare and Senior smiles programs, which aim to meet the healthcare and dental needs of individuals residing in long term and skilled nursing facilities. They employ 60 primary care clinicians, including family physicians, pediatricians, internists, physician assistants, nurse practitioners, behavioral health consultants (BHCs) and dental providers, and serve more than 30,000 people in central Washington with over 65% of patients on Medicaid or Medicare.



Our Mission

Community Health of Central Washington provides quality healthcare through service and education. Community Health of Central Washington was founded with one bold and clear vision: All people in our region should enjoy access to affordable and appropriate health care.

Program Development

• In 2006, Community Health of Central Washington (CHCW) adopted the Primary Care Behavioral Health model of integrated care, led by Kirk Strosahl, PhD. Dr. Strosahl joined CHCW's residency program as a faculty member and clinician. Family physician Deb Gould, MD, was a medical faculty champion for integration of behavioral health, and a pioneer in helping to establish PCBH within the Central Washington Family Medicine clinic of CHCW. Soon after, BHCs were integrated into the Yakima Pediatric and Ellensburg clinics.

• CHCW now provides BHC coverage at their rural clinics, at their main clinic, their Ellensburg clinic, and their pediatric clinic (Yakima Pediatrics). BHCs provide clinical coverage, with several BHCs having specific administrative and residency duties. In 2016, they developed a pre-doctoral internship and postdoctoral fellowship program for psychologists with the first class of trainees beginning in June 2017.

• Over the years, CHCW has grown to employ eleven behavioral health consultants (BHCs) shared among five primary care sites. CHCW has also partnered with Comprehensive Health Care, a local community behavioral health organization, to place one of their employees to work as a BHC in one clinic to help bridge primary and specialty care. These BHCs include psychologists and masters level behavioral health providers, as well as psychology trainees in the form of pre-doctoral interns and postdoctoral fellows.

“We never ‘end’ treatment – we see people for their lifespan, sometimes more frequently.”

Bridget Beachy
Director of Behavioral Health

<http://www.waportal.org/resources/case-example-community-health-central-washington>

<http://www.waportal.org/resources/case-example-seattle-indian-health-board>





Who else is doing this work?

Healthier Washington Practice Transformation Support Hub **Innovative Practice Roster**

January 2018

The Healthier Washington Practice Transformation Support Hub connects primary care providers and behavioral health clinicians with tools, training, and hands-on technical assistance to help them:

- Integrate physical and behavioral health
- Move from volume to value-based care
- Improve population health through clinical community linkages

In communities across Washington State, innovative practices are already leading the way in achieving these three goals. To help other practices on their journey to practice transformation success, the Hub is collecting and sharing successes, challenges and lessons learned from these "model" practices.

Below is a list of practices willing to share their experiences with their peers. Those marked with a star (★) have also agreed to host fellow care teams at their site to see them in action. The primary contact listed can assist with that request.

The Practice Transformation Support Hub continues to learn from practices on the front line of this work, and this roster of innovative practices will be expanded as the network grows.

If you would like to share an innovative practice experience with the Hub, please contact the Hub Help Desk at HubHelpDesk@qualishealth.org or 206-288-5420.



Healthier Washington Practice Transformation Support Hub: Innovative Practice Roster

<http://www.waportal.org/resources/innovative-practice-roster>



Will telepsychiatry work for us?

Key Considerations for Implementing Telepsychiatry Services *in Primary Care Practices*



About this Guide

Primary care providers are managing an increasing number of patients experiencing mental health and chemical dependency concerns. Telepsychiatry has emerged as a potential evidence-based resource to assist primary care providers. This resource is needed for multiple reasons, including shortages of mental health professionals in Washington State, patient comfort in their medical home setting, the lack of stigma associated with behavioral health treatment in the primary care office, efficient use of psychiatrist's time, and the ease of treating patients in rural or under-served areas by eliminating the need for extensive travel.

Telepsychiatry is the application of telemedicine to the specialty field of psychiatry. The delivery of psychiatric assessment and care through telecommunications technology, usually videoconferencing, can be offered through intermediary companies or individuals that partner with practices to increase care capacities. Many providers are considering adding telepsychiatry services in their primary care practices, and there are many important factors to consider, including models, regulations, technology, and implementation. This guide is meant to provide primary care providers with an overview of key considerations for telepsychiatry services, including questions to consider for a practice's unique needs. Additional in-depth resources are also provided at the end of this guide.



<http://www.waportal.org/resources/behavioral-health-integration-through-telepsychiatry-mid-valley-clinic-omak-wa>
<http://www.waportal.org/resources/key-considerations-implementing-telepsychiatry-services>



How do we solve workforce issues?



New people, new roles

- MAs
 - Top of scope
 - Increase comfort with behavioral health discussions
 - Better utilize other care team members' time
 - Assessment administration (e.g. PHQ-9)
 - Chart scrubs; what's needed at this appointment?



New people, new roles

- Nurses
 - Care Coordination
 - Connection to mental health services
 - Telepsychiatry
 - Population health management
 - Focus population proactivity
 - Registry management



New people, new roles

- Physicians, ARNPs, PAs
 - Increase psychiatric medications comfort
 - Build psychiatric consultation channels



New people, new roles

- **Webinar: *Pharmacists in Whole Person Care***
 - Thursday, **April 19, 12:00-1:00pm**
 - Dr. Andrea Corona will describe
 - Scope and role of a pharmacist working in integrated settings in WA State
 - Key steps to utilize the pharmacist role in whole person care
 - Considerations for optimizing this role in practice





New people, new roles

- **Workshop:** *The Expanding Role of Nurses in Whole Person Care*
 - Tuesday, May 22
 - Spokane, WA
 - UW AIMS Center





For More Information



Hub Help Desk: (206) 288-2540 or (800) 949-7536 ext. 2540 or by email HubHelpDesk@qualishealth.org.

Healthier Washington Practice Transformation Support
Hub Web sites:

- Healthier Washington: www.hca.wa.gov/hw/
- Qualis Health: www.QualisHealth.org/hub
- Hub Resource Portal: www.waportal.org

The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

