Practice Transformation Directory

A Washington State Resource Guide

QUALIS HEALTH

Washington State Department of Health

Healthier WASHINGTON

Introduction

Providers, practices and leaders are demonstrating their commitment to a healthier Washington by transforming the way healthcare is delivered in our state.

Primary care practices are at the core of our health system and are well positioned to provide whole-person care. However, to achieve the "Triple Aim" of better care, better health and lower costs, changes need to be made in the way health care is delivered and reimbursed. For some practices, this transformation may require a few important changes. But for others, it may mean a significant re-visioning of the way care is delivered.

There are many resources in Washington State to support practices in these efforts. But to a busy practice already short on time and resources, the offers of help can seem overwhelming.

This directory is designed to help providers understand the range of opportunities available in Washington State to support practice transformation and achieve success in the new value-based payment landscape. Practices can engage with the opportunity (or opportunities) that best fit their needs and goals. All programs included in this directory share the same goal: to help practices achieve sustainable improvements in how primary care is delivered in order to improve the health of all Washingtonians.

What is Practice Transformation?

"Practice Transformation" is a phrase used to describe a change in the process of health care delivery in a primary care practice to improve delivery of care and reduce healthcare costs. Increasingly, the term practice transformation is linked to value-based payment, as payment structures will depend on the achievement of better patient outcomes and employment of comprehensive quality improvement strategies.

Practice Transformation is not a new concept. Some practices have been "transforming" for many years and are already far into the journey towards achieving whole-person care. For patients, these changes – value-based payment, physical and behavioral health integration and stronger community clinical linkages – will mean better health and better outcomes. For providers and their staff, "practice transformation" can be a pathway to making the business of patient care a more satisfying career choice.

About Practice Transformation in Washington State

The Transforming Clinical Practice Initiative (TCPI) is a program of Centers for Medicare and Medicaid Services (CMS) to help providers achieve large-scale health transformation. TCPI established Practice Transformation Networks (PTNs), four of which are active in Washington State. These programs are all distinct, with different focuses and offerings.

The Practice Transformation Support Hub (Hub) is an investment of Healthier Washington managed by the Washington State Department of Health. The Hub includes a practice coaching and regional health connector network, and a website that hosts practice transformation and health system transformation resources. Regional health connectors are available to assist practices determine the best source of support for their needs.

Navigating Practices through the Transformation Journey

Having a framework to guide the practice transformation process can be helpful, and one widely accepted framework used nationally and in Washington State is the Change Concepts for Practice Transformation. This framework was developed through the Safety Net Medical Home Initiative (SNMHI) to help guide primary care practices through the process of practice transformation, and is used by the Practice Transformation Support

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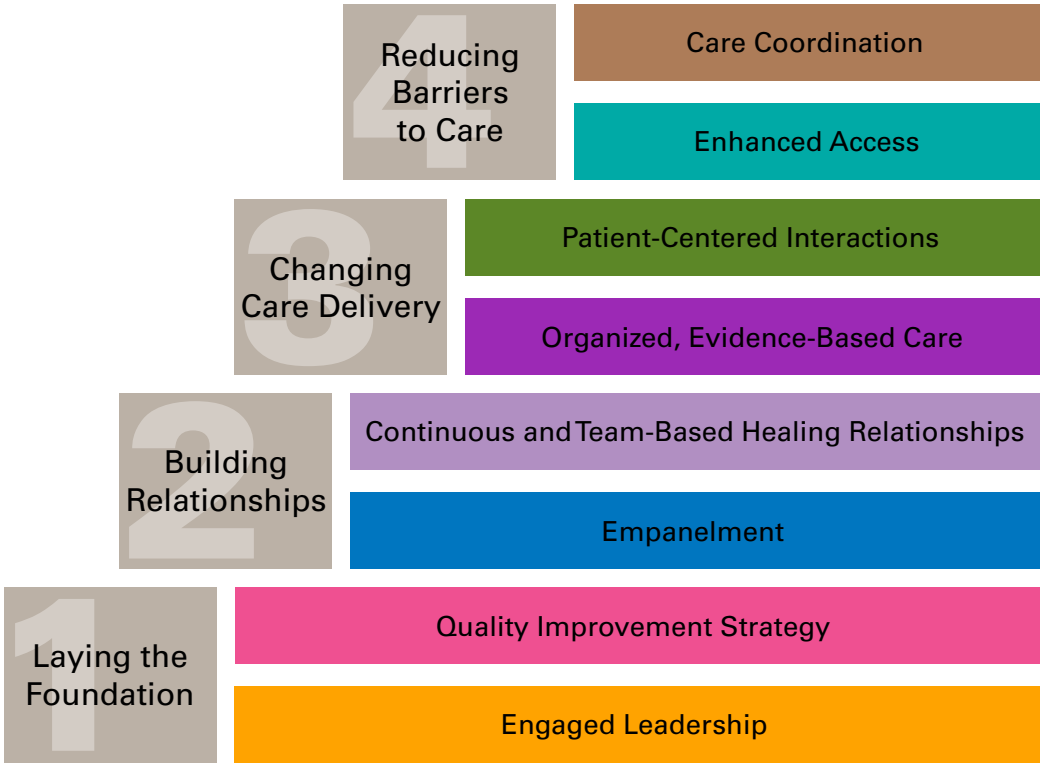
Hub and other practice transformation initiatives in Washington State. It was extensively tested by sixty-five practices participating in the SNMHI, and provides a common language for the process of transforming care delivery and practice.

The framework includes eight change concepts in four stages:

- Laying the Foundation: Engaged Leadership and Quality Improvement Strategy.
- Building Relationships: Empanelment and Continuous and Team-Based Healing Relationships.
- Changing Care Delivery: Organized, Evidence-Based Care and Patient-Centered Interactions.
- Reducing Barriers to Care: Enhanced Access and Care Coordination.



How to Use the Directory

This directory is designed to facilitate independent use by providers and care team members to understand the range of practice transformation opportunities available in Washington State, and make connections to the ones that are most relevant for their practice goals. Standard information on each program is included, along with links to the program website when available, to learn more.

The four Practice Transformation Networks are grouped together at the beginning of the directory, as they all fall under the umbrella of the TCPI.

Contact or enrollment information is provided for each opportunity when available, to facilitate practice engagement. The Practice Transformation Support Hub Help Desk – at 206-288-2540 or HubHelpDesk@qualishealth.org – is available as a resource for any practice seeking to determine the best fit of support for their needs and goals.

National Rural Accountable Care Consortium Practice Transformation Network

Transforming Clinical Practice Initiative (TCPI)

Focus: Practice transformation network assists practices in building key components of a population health management program, with the goals of improving health, reducing costs, and enabling practices to participate in value-based payment models. Practices will be assigned a project manager and practice improvement manager who will provide technical assistance, education, and support. Key areas of focus include:

- Establishing billable care coordination services for Medicare patients
- Redesigning the practice to better manage population health through data analytics
- Increasing practice revenue and clinician satisfaction

Provided by: National Rural Accountable Care Consortium

Partners: Rural health organizations, CMS-funded service and alignment networks

Funded by: Centers for Medicare & Medicaid Services (CMS)

Regional availability: Statewide

Targeted participants: Rural and community primary care, behavioral health, and specialty providers
(note: individual clinicians enrolled in this TCPI network may not enroll in another TCPI network)

Targeted patient populations: All patient populations; cost savings and outcomes are tracked for Medicare patients

Timeframe: September 2015–September 2019

Practice responsibilities:

- Implement the "Roadmap" practice transformation plan
- Train and hire a care coordinator
- Establish billable chronic care management services

Practice benefits:

- Remote technical assistance, including scalable project plan and curriculum
- Practice-level project plan and monthly "roadmap" calls with expert team to present training, check progress, answer questions, and address barriers
- Live, in-person quarterly workshops featuring shared learning and networking opportunities
- Library of on-demand training for flexible learning
- Access to an annual symposium

Contact: Robin Moody: rmoody@nationalruralaco.com

Web: www.nationalruralaco.com/practice-transformation.shtml

PeaceHealth Practice Transformation Network

Transforming Clinical Practice Initiative (TCPI)

Focus: Practice transformation network that works with PeaceHealth-employed clinicians in implementing team-based care models within the practices. Teams work in tandem to integrate clinical findings, health metrics data, and chronic disease registry outcomes in a shared effort to identify high-risk populations, validate success of interventions, and determine opportunities for further intervention. Goals include:

- Improving clinical outcomes
- Improving overall health of individuals and communities
- Preventing unnecessary health expenditures

Provided by: PeaceHealth Ketchikan Medical Center

Partners: N/A

Funded by: Centers for Medicare & Medicaid Services (CMS)

Regional availability: Statewide

Targeted participants: Medicare Physician Quality Reporting System (PQRS)-eligible professionals, critical access hospitals, federally qualified health centers (FQHCs), fee-for-service clinics, and PeaceHealth providers that do not already belong to a Medicare Shared Savings program (MSSP, CPCI, etc.) (note: Individual clinicians enrolled in this TCPI network may not enroll in another TCPI network)

Targeted patient population: PeaceHealth patients

Timeframe: 2015-2019

Practice responsibilities:

- Participate in practice assessments every six months
- Share monthly clinical and outcome results
- Attend national and local training webinars and PTN-led events
- Actively engage in implementation of "best practices" strategies
- Commit to system-wide standardization of "best practices" as developed

Practice benefits: Resources, tools, and practice facilitation that include:

- Onsite, community-specific process improvement and change management support
- Centralized support for billing and data quality reporting
- Care coordination resources to help manage patients with chronic diseases, and social/economic and behavioral health needs
- Implementation of an integrated, system-wide electronic medical record (EMR) to improve communication and coordination of care across settings
- Assistance moving toward alternative payment models (APMs)

Contact: Eric Blake, EBlake@peacehealth.org

Pediatric - Transforming Clinical Practice Initiative

Focus: Practice transformation network that works to improve health outcomes and reduce hospitalizations and overutilization of other services for 450,000 Washington children on Medicaid and the Children's Health Insurance Program. The program assists clinicians in adopting care delivery strategies for integrating quality and process improvement to provide evidence-based, efficient, coordinated and patient/family-centered care, with particular focus on:

- Improving asthma care, well-child check-ups, and immunizations
- Decreasing avoidable emergency room visits and hospital admissions
- Improving access to pediatric behavioral healthcare
- Implementing clinical business operations that take advantage of value-based payment reform

Provided by: Washington State Department of Health

Partners: Washington Chapter of American Academy of Pediatrics (WCAAP) and Molina Healthcare

Funded by: Centers for Medicare & Medicaid Services (CMS)

Regional availability: Statewide

Targeted participants: Primary care and behavioral health pediatric practices, practices with an emphasis on rural and underserved areas (note: Individual clinicians enrolled in this TCPI network may not enroll in another TCPI network)

Targeted patient population: 0–21 years old, Medicaid

Timeframe: 2015–2019

Practice responsibilities:

- Senior management facilitates practice-wide participation
- Dedicate staff time to conduct practice improvement activities throughout the project period
- Conduct monthly reporting on three clinical and one process improvement measure as determined by the clinic's practice assessment and ability to report
- Participate in monthly events, including webinars, community workshops, and/or practice facilitator site visit
- Complete a practice assessment tool every six months

Practice benefits:

- Free support for you and your staff to improve care for your patients
- Preparation for value-based reimbursement and sustaining your business
- Free continuing medical education (CME) and support for Maintenance of Certification for Quality Improvement (MOC/QI) certification
- Support for behavioral health integration
- Ongoing reports on key clinical and utilization metrics on Molina patients
- Payment for care coordination for clinics participating in Health Home Care Coordination Organization training

Pediatric - Transforming Clinical Practice Initiative

Financial incentives: Modest incentives for completing assessments and for formal working agreements with behavioral health clinics and vice versa.

Contact: Melissa Thoemke, melissa.thoemke@doh.wa.gov

Web: www.wcaap.org/pediatrictcpi

WWAMI (Washington, Wyoming, Alaska, Montana and Idaho) Practice Transformation Network

Transforming Clinical Practice Initiative (TCPI)

Focus: Practice transformation network that works to improve population health outcomes, reduce hospitalizations, and avoid overutilization of services. Practices receive access to the national TCPI curriculum and locally developed tools and resources, as well as customized assistance to prepare for the transition to value-based payment models across the spectrum of care delivery. Core elements include:

- Improving general population health outcomes for all patients
- Reducing unnecessary healthcare utilization through evidence-based care standardization and incorporation of shared decision-making in specialty care and primary care
- Reducing avoidable hospitalizations

Provided by: UW Medicine

Partners: UW Medicine Accountable Care Network, and WWAMI Region Practice and Research Network

Funded by: Centers for Medicare & Medicaid Services (CMS)

Regional availability: Statewide

Targeted participants: Primary care and specialty care practices affiliated with UW Medicine, the UW Medicine Accountable Care Network, and the WWAMI Region Practice and Research Network, and select organizations in the greater WWAMI region (note: Individual clinicians enrolled in this TCPI network may not enroll in another TCPI network)

Targeted patient population: All patient populations

Timeframe: September 2015–September 2019

Practice benefits:

- Advanced training and collaborative learning groups to foster adoption of "best practices" in primary care coordination of high-risk, complex patients
- Training and skill building in quality improvement, process improvement, and change management
- Technical assistance and connection to resources that align with practice's transformation goals
- Forums for networking and shared learning across enrolled practices
- Access to national TCPI curriculum and associated resources, as well as best practice toolkits developed out of UW Medicine for primary and specialty care transformation topics

Contact: BrieAna White, brieana@uw.edu, 206-221-6387

Web: http://depts.washington.edu/uwmedptn/

Practice Transformation Support Hub

Focus: An investment area of Healthier Washington managed by the Washington State Department of Health that provides technical assistance and connections to resources for bi-directional integration, value-based payment preparation and enhanced community clinical linkages. Promotes improvement of regional care delivery through regionally based, on-site practice coach/connectors, learning events and a web-based resource portal.

Provided by: Washington State Department of Health

Partners: Qualis Health, University of Washington Department of Family Medicine Primary Care Innovation Lab

Funded by: Centers for Medicare & Medicaid Services (CMS)

Regional availability: Statewide

Targeted participants: Primary care and behavioral health providers, small/medium practices with fewer than 20 providers

Targeted patient population: All populations

Timeframe: October 2016–2019

Practice responsibilities:

- Designate leaders and convene team to develop and work on improvement milestones
- Collaborate with practice coaches to complete a self-evaluation and create improvement plan
- Participate in face-to-face visits and/or a monthly phone call with a coach
- Complete subsequent self-evaluation every six months to measure progress.

Practice benefits:

- Introductory "readiness assessment" for practice transformation
- Ongoing assessment and monitoring of practice transformation goals by regional practice coaches
- Preparation for transition to value-based payment models
- Access to regional and statewide training events and webinars
- Access to regional and statewide practice transformation community resources

Contact: Selena Bolotin, selenab@qualishealth.org, 206-288-2472

Web: www.waportal.org/

Quality Innovation Network-Quality Improvement Organization (QIN-QIO)

Medicare Quality Payment Program

Focus: Regional support project for the Medicare Quality Payment Program—a component of MACRA (the Medicare Access and CHIP Reauthorization Act of 2015)—focused on large clinics, that support clinicians in improving delivery of quality care and transitioning from volume-based payment to value-based models. Participating practices receive ongoing support through education, peer networks, and technical assistance. The program features a resource center with content contributed by Quality Payment Program (QPP) subject matter experts who respond to questions in real time and assess providers' needs for ongoing technical assistance. QPP is budget neutral, with potential for providers to be penalized or incentivized up to 4%. Active engagement increases the likelihood that a practice can avoid penalties and earn significant incentives.

Provided by: Qualis Health

Partners: Washington Academy of Family Physicians, Washington State Hospital Association, Washington State Medical Association

Funded by: Centers for Medicare & Medicaid Services (CMS)

Regional availability: Statewide

Targeted participants: Practices composed of groups of more than 15 practitioners who are not already enrolled in the TCPI or an Advanced Alternative Payment Model

Targeted patient population: Medicare Part B

Timeframe: Current–July 2019

Practice responsibilities: Participate in the Quality Payment Program

Practice benefits:

- Access to web-based educational resources, including Merit-based Incentive Payment System (MIPS) trainings and a QPP toolkit
- "Office hours" series of webinars
- Peer-to-peer support
- Virtual work groups

Contact: QPP-SURS@qualishealth.org, 1-877-560-2618

Website: www.Medicare.QualishHealth.org/QPP

Small, Underserved and Rural Support (SURS)

Medicare Quality Payment Program

Focus: Regional support project for the Medicare Quality Payment Program—a component of MACRA (the Medicare Access and CHIP Reauthorization Act of 2015)—focused on small, underserved, and rural clinics, that supports clinicians in improving delivery of quality care and transitioning from volume-based payment to value-based models. Participating practices receive ongoing support through education, peer networks, and technical assistance. The program features a resource center with content contributed by QPP subject matter experts who respond to questions in real time and assess providers' needs for ongoing technical assistance. QPP is budget neutral, with potential for providers to be penalized or incentivized up to 4%. Active engagement increases the likelihood that a practice can avoid penalties and earn significant incentives.

Provided by: Qualis Health

Partners: Washington Academy of Family Physicians, Washington State Hospital Association, Washington State Medical Association

Funded by: Centers for Medicare & Medicaid Services (CMS)

Regional availability: Statewide

Targeted participants: Small, underserved, and rural clinics with groups of 15 or fewer practitioners who are not already enrolled in the TCPI or an Advanced Alternative Payment Model

Targeted patient population: Medicare Part B

Timeframe: February 2017– February 2022

Practice responsibilities: Participate in the Quality Payment Program

Practice benefits:

- Access to web-based educational resources, including Merit-based Incentive Payment System (MIPS) trainings and a QPP toolkit
- "Office hours" series of webinars
- Peer-to-peer support
- Virtual work groups

Contact: QPP-SURS@qualishealth.org, 1-877-560-2618

Website: www.Medicare.QualishHealth.org/QPP

Washington Association of Community and Migrant Health Centers (WACMHC)

Focus: Ongoing programs to strengthen and advocate for Washington's Community Health Centers as they build healthcare access, innovation, and value. Primary aim is to ensure that all Washingtonians have access to primary healthcare, regardless of geographic location, nationality, income level, or insurance status. Clinic engagement includes programmatic support, training, and technical assistance in administration and care delivery, including outreach and enrollment, quality improvement and practice transformation, data analysis, workforce development, oral health, and behavioral health.

Provided by: Washington Association of Community and Migrant Health Centers

Partners: Community Health Ventures, National Association of Community Health Centers, Washington State Department of Health, Washington State Department of Social and Health Services, Washington Dental Service Foundation, National Oral Health Innovation and Integration Network (NOHIIN)

Funded by: Federal, state, local and private grants

Regional availability: Statewide

Capacity: No set capacity, but practices must apply through WACMHC

Targeted participants: Community health centers, migrant health centers, urban American Indian health programs

Targeted patient population: Low-income, uninsured, and underserved Washington populations served by community health centers

Timeframe: Ongoing

Practice responsibilities: Practices must serve as a community health center and must:

- Reach medically underserved communities
- Govern with community involvement as non-profits
- Treat patients regardless of ability to pay
- Provide a comprehensive scope of services

Practice benefits: Training, educational opportunities, and technical assistance, including:

- Peer-to-peer learning and information sharing
- Assistance with data analysis and population health reporting
- Access to "best practices" and tools for a variety of quality improvement efforts
- Medical Assistant and Dental Assistant Apprenticeship programs to enhance workforce capacity

Contact: 360-786-9722

Web: www.wacmhc.org

Washington State Medical Association (WSMA) Practice Resource Center

Focus: Ongoing program that helps member physicians' practices improve clinical and business processes and outcomes. Provides guidance on practice operational issues and advocacy with payer organizations.

Provided by: Washington State Medical Association

Partners: American Medical Association, Physicians Insurance A Mutual Company, local county medical societies, and state specialty societies

Funded by: Washington State Medical Association

Regional availability: Statewide

Targeted participants: WSMA member physicians and physician assistants, and practice staff of members

Targeted patient population: None

Timeframe: Ongoing

Practice responsibilities: None required

Practice benefits:

- Free and discounted continuing medical education (CME)
- Compliance support
- Coding and reimbursement assistance
- Advocacy with payer organizations for resolution of denied or delayed claims
- Guidance navigating continual developments in healthcare

Contact: Bob Perna: rjp@wsma.org, 206-441-9762

Web: www.wsma.org

Improving Care in Washington's Community Health Centers

Focus: Community Health Plan of Washington's (CHPW) Care Improvement Team engages directly with community health centers across the state to support quality improvement strategies and improve clinical outcomes and patient satisfaction. The program encourages performance improvement and practice transformation with a focus on the state's value-based payment measures, access to care for all ages, and patient satisfaction. Key strategies include:

- Collaborating with practices to establish annual quality improvement priorities
- Sharing quality improvement best practices among community health centers
- Providing useful, actionable data to community health centers to inform and enhance improvement projects with a focus on access to care and chronic disease management

Provided by: Community Health Plan of Washington (CHPW)

Partners: Community Health Network of Washington (CHNW)

Funded by: CHPW

Regional availability: Statewide

Targeted practices: Nineteen CHNW member community health centers from around Washington State.

Targeted patient populations: Medicaid and Medicare

Timeframe: Ongoing

Practice responsibilities: Must be a member of CHNW Primary contact with the designated Quality Lead from each Community Health Clinic

Practice benefits:

- Support in achieving financial incentives for improved quality performance on selected measures through CHPW's pay for performance program
- Development of shared work plan to focus improvement work on an annual basis
- Web-based and in-person Network learning opportunities to exchange ideas and share best practices
- Support and capacity building on workflow design and implementation, patient access, chronic and preventive care, cultural competence, and population health management
- Technical assistance with operationalizing clinical data to drive improvement

Contact: CHPW's Care Improvement Team; care.improvement@chpw.org

Website: www.chpw.org

Mental Health Integration Program (MHIP)

Focus: Program that provides high quality mental health screening, treatment and monitoring as part of an evidence- and outcome-based Collaborative Care approach to treat common mental conditions experienced by patients who are being served primarily in Federally Qualified Community Health Centers. The program is unique in supporting the Collaborative Care model and includes:

- Integrated mental health care coordinators in a physical health setting
- Caseload workflow management using an electronic registry
- Regular psychiatric consultation
- Emphasis on evidence-based practices
- Use of screening and tracking tools
- Use of Quality Aims/pay for performance

Provided by: Community Health Plan of Washington

Partners: University of Washington AIMS Center, Public Health Seattle and King County

Funded by: Community Health Plan of Washington (CHPW) and Public Health - Seattle & King County. This program received funding from the King County Veterans and Human Services Levy.

Regional availability: Statewide

Targeted practices: Nineteen community health center Members of the Community Health Network of Washington

Targeted patient populations: Community Health Plan of Washington Members; King County Veterans, Veterans' Families, Moms, Uninsured and Older Adults.

Timeframe: Ongoing

Practice responsibilities:

- Ensure that the care team is trained in the Collaborative Care model
- Hire or reallocate a Collaborative Care team member who is licensed to deliver mental health services
- Develop clinic workflows to ensure that patients are appropriately screened and referred to Care Coordinator
- Document patient encounters and care through CHPW's web-based information tracking system, MHITS

Practice benefits:

- Training in Collaborative Care model provided by the University of Washington AIMS Center
- Access and support for MHITS, behavioral health population registry
- Psychiatry consultation support from the University of Washington Psychiatry Department
- Financial support to improve access to mental health in primary care

Contact: Stephanie Shushan, stephanie.shushan@chpw.org, 206-613-5021

Website: https://aims.uw.edu/washington-states-mental-health-integration-program-mhip

Population Health Planning Guide

The Population Health Planning Guide (Guide) website is a collection of information, tools and resources to promote population health initiatives in Washington State. The Guide is part of the Hub's Resource Portal, and content is managed by the Washington State Department of Health. The resources on this website can help you:

- Learn more about population health
- Create a plan to improve a health issue in your community
- Turn your plan into action

There are also process tools and resources for population health assessment, community engagement, goal setting and evaluation.

The Guide covers several key health focus areas including diabetes, obesity, tobacco and well-child visits. More focus areas will be added over time, so please check back often.

Questions or comments? Contact Guide staff at P4IPH@doh.wa.gov

Visit the Guide at: http://www.waportal.org/population-health-planning-guide

Advancing Integrated Mental Health Solutions (AIMS) Center

Focus: The AIMS Center is a collaborative care implementation and training center housed in the Department of Psychiatry and Behavioral Sciences at the University of Washington. The AIMS Center website offers an extensive Resource Library and comprehensive Implementation Guide that practices can use to successfully implement evidence-based collaborative care programs. In addition to the free implementation resources, the AIMS Center also offers training, population-based patient tracking registry options, and ongoing implementation support to clinics around Washington State and nationwide.

Provided by: University of Washington AIMS Center

Partners: To see a list of partners, visit the AIMS Center's Partners and Funders webpage

Funded by: Federal, State, and private grant funding

Regional availability: Nationwide

Targeted practices: Primary care, rural health centers, federally qualified health centers, behavioral health agencies, hospital systems, Accountable Communities of Health

Targeted patient populations: Varies

Timeframe: Ongoing

Practice responsibilities: Varies

Practice benefits:

- Behavioral health integration/collaborative care implementation training and support
- Free tools and resources for implementing collaborative care programs
- Licensing options available for fee-based, HIPAA-compliant, cloud-based registries
- Certification and continuing education contact hours in problem-solving treatment
- Support surrounding behavioral health integration codes, reimbursement, and sustainability

Contact: AIMS Center; uwaims@uw.edu

Website: http://aims.uw.edu/

University of Washington Psychiatry and Addictions Case Conference (UW PACC) Program

Focus: The UW Psychiatry and Addictions Case Conference (UW PACC) is a free, weekly teleconference that connects community providers with UW Medicine psychiatrists and addictions experts. UW PACC has two parts, an educational presentation on rotating addictions and psychiatry topics and case presentations where providers receive feedback and recommendations for patient cases. This program is run through the Integrated Care Training Program (ICTP) at the University of Washington.

Provided by: University of Washington Integrated Care Training Program

Funded by: Washington State Legislature through the Safety-Net Hospital Assessment bill

Regional availability: Statewide

Targeted patient populations: None

Timeframe: Ongoing

Practice responsibilities: None required

Practice benefits:

- Education on various addictions and psychiatry topics
- Telehealth resource support to build the confidence and skills of providers who care for patients with mental and behavioral health conditions
- Up to 1.5 continuing medical education credits per session for participating providers

Contact: UW PACC team; uwpacc@uw.edu

Website: http://ictp.uw.edu/programs/uw-pacc

University of Washington Integrated Care Training Program (ICTP)

Focus: The Integrated Care Training Program (ICTP) at the University of Washington strives to improve the health of Washingtonians by preparing a workforce to advance effective, integrated behavioral healthcare. ICTP offers a variety of continuing education programs for all members of a care team such as the UW Psychiatry and Addictions Case Conference, Community-Based Integrated Care Fellowship, and psychiatric provider training in integrated care.

Provided by: University of Washington

Funded by: Washington State Legislature through the Safety-Net Hospital Assessment bill

Regional availability: Statewide

Targeted audience: Fellows and residents

Targeted patient populations: None

Timeframe: Ongoing

Practice responsibilities: None required

Practice & participant benefits:

- One-day community trainings around Washington State
- Continuing medical education credits for a variety of trainings, programs, and presentations related to behavioral health integration
- Education on implementing, building, and sustaining a successful collaborative care program

Contact: ICTP team; uwictp@uw.edu

Website: http://ictp.uw.edu/

Community-Based Integrated Care Fellowship

Focus: This yearlong program welcomes psychiatric providers seeking additional training to deliver integrated care in community-based settings. This training program is structured as an employment-friendly program with a priority of flexibility in scheduling, including a self-paced distance learning component and quarterly in-person specialized skills work sessions. Participation is free for Washington State providers, but participants will be responsible for travel costs and a nominal fee for continuing medical education credit.

Provided by: University of Washington Integrated Care Training Program

Funded by: Washington State Legislature through the Safety-Net Hospital Assessment bill

Regional availability: Washington State

Targeted audience: Psychiatric providers, including psychiatrists, psychiatric ARNPs, and psychiatric PAs

Targeted patient populations: None

Timeframe: Ongoing, one-year commitment

Participant responsibilities: Varies

Participant benefits:

- Education on using telepsychiatry and other technologies to help areas in the state with no current psychiatric providers
- Training on working with an integrated mental healthcare team in primary care settings
- In-person and distance learning in the following areas:
  - core collaborative care skills
  - telepsychiatry
  - establishing an integrated care practice
  - delivering care for special populations
  - ins and outs of billing/payment codes

Contact: ICTP team; uwictp@uw.edu

Website: http://ictp.uw.edu/programs/community-based-integrated-care-fellowship

Washington Rural Health Care Collaborative

Focus: The Collaborative is an existing, mature, and robust rural network consisting of 13 Critical Access Hospitals, all separately governed and predominately serving the rural areas of Washington. The mission of the Collaborative is to stimulate innovation through agile partnerships that improve rural healthcare quality, efficiency, and sustainability. The primary focus in the last few years has been to prepare hospitals and clinics for the transformation to value-based care and contracts using a combination of consultants, staff, and peers to support the learning. Multiple assessment tools, benchmarking, and evaluation are utilized to support transformation.

Provided by: Washington Rural Health Care Collaborative

Funded by: Membership dues, grants, and program fees

Regional availability: Statewide, upon approval from Board

Targeted participants: Critical Access Hospital and employed clinics

Targeted patient populations: Critical Access Hospital and employed clinics

Timeframe: Incorporated in 2003

Contact: Holly Greenwood; holly@washingtonruralhealth.org

Website: http://www.wwrhcc.org/

Integrated Health Care Alliance (IHCA)

Focus: Integrating behavioral health clinicians into primary care settings and preparing them to participate in value-based payment models (including alternative payment models).

Provided by: American Psychological Association (APA)

Partners: American Psychological Association Practice Organization (APAPO)

Funded by: Center for Medicare & Medicaid Innovation (CMMI)

Regional availability: National

Targeted practices: Behavioral health clinicians and mental health specialists; licensed psychologists; licensed clinical social workers

Targeted patient populations: Primary care patients with complex needs

Timeframe: Recruiting through July 2018

Practice responsibilities:

- Complete a baseline Practice Readiness Assessment Tool (PRAT) and three follow-up assessments. These PRATs will be conducted by the regional QIN-QIO (Qualis Health is the QIN-QIO for Washington State).
- Submit quality measures to APA throughout the project duration.

Practice benefits:

- Access to APA's brand-new, free training courses: a six-hour training on Integrated Primary Care for six CE credits and a two-hour training on payment models to thrive in a value-based world for two CE credits
- New business skills to succeed in a changing healthcare environment
- Participation in a network of behavioral health specialists in the practice transformation process to learn from each other's progress
- Being pioneers in taking the field of psychology in a new direction, while advocating for psychology's important role in new healthcare directions

Contact: Emily Schenck; 202-336-5531; eschenck@apa.org

Website: http://pages.apa.org/ihca/

FAQ page for clinicians: http://www.apa.org/ihca/clinicians-faq.aspx

Better Health Together

Focus: BHT has a vision that every person in our region, regardless of environment, background, or life experiences, will live a productive, high quality life by ensuring access to an integrated whole person health care system. The ACH is made up of a variety of community partners representing multiple sectors and communities. Partners share a common interest in delivery system transformation (e.g., integrated care), clinical-community linkages, social determinants of health, and foundational strategies (e.g., workforce, value based payment, health information technology and exchange). Transformation efforts are designed and coordinated by the ACH with funding or other assistance available to participating providers.

Partners: In addition to 75+ partnering community organizations that make up the ACH, key state partners include the Health Care Authority, Department of Health, Department of Social and Health Services, Washington State Hospital Association, Washington State Medical Association, Medicaid Managed Care Organizations, etc.

Funded by: Braided funding, with the majority of funding from CMS through the Health Care Authority under the Medicaid Transformation.

Regional availability: Spokane, Stevens, Pend Oreille, Adams, Ferry, Lincoln counties. Kalispel Tribe, Spokane Tribe, and Colville Confederated Tribes.

Recipients / Partnering Providers: Defined as part of 2018 implementation plans, partnering providers could include regional hospitals; health systems; emergency medical systems, jails, primary care, oral health, and behavioral health providers; community based organizations; tribes and Urban Indian Health Programs, etc.

Patient focus: Entire population with an emphasis on Medicaid providers and beneficiaries. Target populations for Medicaid Transformation efforts will be defined as part of 2018 implementation plans.

Timeframe: Medicaid Transformation efforts of the 1115 Waiver will run from 2017-2021.

Contact: Hadley Morrow, Associate Director, hadley@betterhealthtogether.org

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Cascade Pacific Action Alliance (CPAA)

Focus: CPAA is an original pilot Accountable Community of Health in central western Washington. CPAA is made up of a variety of regional partners and stakeholders representing a diversity of sectors, organizations, and communities. Partners share a common interest in regional health improvement, delivery system transformation (e.g., integrated care), clinical-community linkages, social determinants of health, and foundational strategies (e.g., workforce, value based payment, health information technology and exchange). Transformation efforts are designed and coordinated by CPAA with funding and other assistance available to participating providers.

Partners: In addition to community partners that make up CPAA, key state partners include the Health Care Authority, Department of Health, Department of Social and Health Services, and other statewide partners, such as the Washington State Hospital Association, Washington State Medical Association, and Medicaid Managed Care Organizations.

Funded by: Braided funding, with a majority of funding from CMS through the Health Care Authority under the Medicaid Transformation.

Regional availability: Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, and Wahkiakum counties.

Recipients / Partnering Providers: Arcora Foundation, Area Agency on Aging & Disabilities of SW WA, Capital Region ESD 113, Child and Adolescent Center, Child Care Action Council, Coastal Community Action Program, Cowlitz Family Health Center, Crisis Clinic, Family Education and Support Services, Grays Harbor Community Hospital, Great Rivers BHO dba Community Integrated Health Services, Housing Opportunities of SW WA, Lacey Fire District #3, Lewis County Health and Social Services, Lower Columbia CAP, Mason County Health and Social Services, Mason General Hospital, Morton General Hospital, Nisqually Tribal Health Department, Ocean Beach Hospital and Medical Clinic, PeaceHealth, Physicians of SW WA, Providence Health and Services, Sea Mar Community Health Clinic, Thurston County Public Health and Social Services, and Youth and Family LINK are all current partnering providers. This list continues to grow as CPAA builds relationships within the region.

Patient focus: Entire population with an emphasis on Medicaid providers and beneficiaries. Target populations for Medicaid Transformation efforts will be defined as part of 2018 project implementation plans.

Timeframe: 2017-2021 for the Medicaid Transformation, although this effort does not represent all current and future CPAA activities.

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Greater Columbia Accountable Community of Health (GCACH)

Program Focus: The community partners and stakeholders across the nine counties of the GCACH have come together through a coordinate Collective Impact model of collaboration, focusing on four central themes:

- System Integration will be used to integrate care between medical providers, social service agencies, public health jurisdictions, EMS and more.
- Community Engagement will utilize social and electronic media, health fairs, the GCACH website, and more to educate the community and draw attention to campaigns that will focus on diabetes, ED utilizations, end-of-life care and more.
- Health Equity & Social Determinants of Health will ensure that care is provided equitably across all races, ethnicities and other minority populations. It also takes into consideration that true health involves sustainable housing, employment, education and other social determinants of health.
- Coordination of Care implies that all providers working with a particular client share important clinical information and have clear, shared expectations about their roles. Equally important, they ensure that effective transitions between providers (clinical and social) take place. In part this will take place through collaboration but also through technology.

The inevitable outcome from focusing on these four areas in a systematic way will be improved population health, transformative care processes, enhanced well-being and lower care costs. The programs we organize and fund, and accompanying contractual relationships we form, will drive these concepts forward.

Partners: Community partners and stakeholders to the ACH number over 400. These include local health jurisdictions, hospitals and health systems, Federally Qualified Healthcare Centers, EMS agencies, transportation planning organizations, elected community officials, charitable and philanthropic organizations, faith-based organizations, social service agencies, behavioral health providers, educational organizations, housing agencies, workforce development organizations, the Yakama Nation Federated Tribes, and more as well as MCOs, CCHE, DSHS, HCA, DOH, WSMA, and WSHA.

Funded by: The majority of the GCACH's funding will come through CMS Medicaid Waiver funding, directed through the Health Care Authority. However, additional funding may come through grant writing and braided funding through Medicaid providers, Managed Care Organizations, local government and possibly more.

Regional availability: Greater Columbia ACH covers nine counties in south central and south east Washington, including Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Garfield, Asotin and Whitman counties. In addition, the GCACH includes the Yakama Nation Indian Reservation.

Recipients / Partnering Providers: Prospective partnering providers to the GCACH are expected to be from Behavioral Health, Education, Food System, Community-Based, Faith-Based, FQHC, Healthcare Provider, Hospital, Public Health District, Public Safety, Social Services, and Transportation sectors.

Patient focus: The program scope includes the Medicaid population across the nine-county GCACH, which comprise around 256,000 people. However, emphasis will be placed on high-needs, high-utilizing patients that have multiple chronic conditions, behavioral health conditions, disabilities, high social service needs and more. There will also be community wide campaigns that focus on broader populations with the intention of promoting a culture of health and appropriate utilization of healthcare resources (e.g. Emergency Department services).

Timeframe: 2017-2021 is the time period for the Medicaid Transformation projects. Through sustainable funding and positive achievement across performance measures, as well as a positive return on investment across project areas, we expect the GCACH's work to extend beyond the Transformation timeframe.

Greater Columbia Accountable Community of Health (GCACH)

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HealthierHere

Program Focus: HealthierHere is a newly created non-profit Limited Liability Company (LLC) and subsidiary of the Seattle Foundation. Our vision is that "by 2020, the people of King County will experience significant gain in health and well-being because our community worked collectively to make the shift from a costly, crisis-oriented response to health and social problems, to one that focuses on prevention, embraces recovery, and eliminates disparities."

HealthierHere is moving forward a portfolio of delivery system reform activities in alignment with the Health Care Authority's Healthier Washington plan and goals as described in the Medicaid Transformation Project Toolkit. HealthierHere's project portfolio includes activities related to integrated, whole person care, chronic disease prevention and control, transitional care, and addressing the opioid crisis. In addition, HealthierHere is committed to system transformation activities that include robust care coordination, addressing the social determinants of health, and reducing health disparities in the region.

Partners: HealthierHere is governed by a 24 member, multi-sector Board that includes representatives from the community, community based organizations, community health and behavioral health centers, hospital/health systems, governmental agencies, long-term services, housing and managed care orgnizations. In addition to community partners that make up the ACH, key state partners include the Health Care Authority, Department of Health, Department of Social and Health Services, Washington State Hospital Association, and Washington State Medical Association, etc.

Funded by: Primary funding for HealthierHere comes from CMS through the Health Care Authority under the Medicaid Transformation Project with in-kind supports from community partners.

Regional availability: King County

Recipients / Partnering Providers: Defined as part of 2018 implementation plans, partnering providers could include regional hospitals; health systems; primary care, oral health, and behavioral health providers; community based organizations; tribes and Urban Indian Health Programs, etc.

Patient focus: Entire population with an emphasis on Medicaid providers and beneficiaries. Target populations for Medicaid Transformation efforts will be defined as part of 2018 implementation plans.

Timeframe: 2017-2021 for the Medicaid Transformation Project, although this effort does not represent all future ACH activities.

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North Central Accountable Community of Health (NCACH)

Focus: Program Focus: The North Central Accountable Community of Health uses Whole Person Care as a guiding tenet in our design and delivery. By ensuring that patients have a say in their care, we can ensure that our region's providers are achieving the 'quadruple aim': better quality, experience, [lower] cost for all, and provider satisfaction. Whole Person Care relies on an integrated network of primary care and behavioral health providers who are committed to creating and exceeding new standards of care in the North Central Region. NCACH has selected six projects to focus on over the next year to transform the way we deliver care. They are: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation, Community-Based Care Coordination, Transitional Care, Diversion Interventions, Addressing the Opioid Use Public Health Crisis, and Chronic Disease Prevention and Control.

Partners: In addition to the partnership and input received from community partners and Medicaid consumers within the ACH, key state partners include the Health Care Authority, Department of Health, Department of Social and Health Services, Washington State Hospital Association, Washington State Medical Association, Medicaid Managed Care Organizations, etc.

Funded by: CMS through the Health Care Authority under the Medicaid Transformation Project and State Innovation Model Grant

Regional availability: Chelan, Douglas, Grant, and Okanogan Counties

Recipients / Partnering Providers: Defined as part of 2018 implementation plans, partnering providers include regional hospitals, health systems, primary care, and behavioral health providers, community based organizations, and tribal health entities.

Patient focus: Entire population with an emphasis on Medicaid providers and beneficiaries. Target populations for Medicaid Transformation efforts will be defined as part of 2018 implementation plans.

Timeframe: 2017-2021 for the Medicaid Transformation project, although this effort does not represent all future ACH activities.

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North Sound Accountable Community of Health (North Sound ACH)

Program Focus: The North Sound ACH is an independent non-profit entity with participation from a variety of community partners representing multiple sectors and communities. Partners share a common interest in delivery system transformation (e.g., integrated care), clinical-community linkages, social determinants of health, and foundational strategies (e.g., workforce, value based payment, health information technology and exchange). Transformation activities will be designed and coordinated by the ACH and its partners with workforce trainings, leadership development, capacity building, and other forms of assistance available to participating providers.

Partners: In addition to community partners that make up the ACH, key state partners include the Health Care Authority, Department of Health, Department of Social and Health Services, Washington State Hospital Association, Washington State Medical Association, Medicaid Managed Care Organizations, etc.

Funded by: Braided funding model, with the majority of development and planning funds from CMS through the Health Care Authority under the Medicaid Transformation Project. Project Implementation funds earned by the region will be held by an independent financial executor and dispersed to regional partnering providers as designated by the ACH.

Regional availability: The North Sound ACH region comprises Island, San Juan, Skagit, Snohomish, and Whatcom counties, and eight sovereign tribes.

Recipients / Partnering Providers: Partnering providers will include clinical and community based service providers, and tribal partners.

Population focus: People of the North Sound region with an emphasis on reducing health disparities and improving health equity. Initial pilot populations and evidence based strategies for Medicaid Transformation will be defined in the 2018 implementation plan.

Timeframe: The Medicaid Transformation project planning and implementation process will occur between 2017 and 2021. The North Sound ACH will participate in activities outside the scope of the transformation project timeline as well.

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Olympic Community of Health

Focus: The ACH is made up of a variety of community partners representing multiple sectors and communities. Partners share a common interest in delivery system transformation (e.g., integrated care), clinical-community linkages, social determinants of health, and foundational strategies (e.g., workforce, value based payment, health information technology and exchange). Transformation efforts are designed and coordinated by the ACH with funding or other assistance available to participating providers.

Partners: In addition to community partners that make up the ACH, key state partners include the Health Care Authority, Department of Health, Department of Social and Health Services, Washington State Hospital Association, Washington State Medical Association, Medicaid Managed Care Organizations, etc.

Funded by: Braided funding, with the majority of funding from CMS through the Health Care Authority under the Medicaid Transformation Project.

Regional availability: Olympic Community of Health (OCH) is an accountable community of health; one of nine in the state. Our region includes Clallam, Jefferson and Kitsap Counties, which are located on ancestral lands of seven sovereign nations: Hoh, Jamestown S'Klallam, Lower Elwha Klallam, Makah, Port Gamble S'Klallam, Quileute and Suquamish Tribes.

Recipients / Partnering Providers: Defined as part of 2018 implementation plans, partnering providers could include regional hospitals; health systems; primary care, oral health, and behavioral health providers; community based organizations; tribes and Urban Indian Health Programs, etc.

Patient focus: Entire population with an emphasis on Medicaid providers and beneficiaries. Target populations for Medicaid Transformation efforts will be defined as part of 2018 implementation plans.

Timeframe: 2017-2021 for the Medicaid Transformation Project, although this effort does not represent all future ACH activities.

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Pierce County ACH

Program Focus: The ACH is made up of a variety of community partners representing multiple sectors and communities. Partners share a common interest in delivery system transformation (e.g., integrated care), clinical-community linkages, social determinants of health, and foundational strategies (e.g., workforce, value based payment, health information technology and exchange). Transformation efforts are designed and coordinated by the ACH with funding or other assistance available to participating providers.

Partners: In addition to community partners that make up the ACH, key state partners include the Health Care Authority, Department of Health, Department of Social and Health Services, Washington State Hospital Association, Washington State Medical Association, Medicaid Managed Care Organizations, etc.

Funded by: Braided funding, with the majority of funding from CMS through the Health Care Authority under the Medicaid Transformation Project.

Regional availability: Pierce County

Recipients / Partnering Providers: Defined as part of 2018 implementation plans, partnering providers could include regional hospitals; health systems; primary care, oral health, and behavioral health providers; community based organizations; tribes and Urban Indian Health Programs, etc.

Patient focus: Entire population with an emphasis on Medicaid providers and beneficiaries. Target populations for Medicaid Transformation efforts will be defined as part of 2018 implementation plans.

Timeframe: 2017-2021 for the Medicaid Transformation Project, although this effort does not represent all future ACH activities.

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Southwest Washington Accountable Community of Health (SWACH)

Program Focus: SWACH is a community based non-profit organization that is dedicated to transforming how health care is delivered in our region. We are represented by cross system partnerships and share a common interest in working collaboratively toward achieving better health outcomes at a lower cost for individuals and families in our communities. We are particularly focused on creating community linkages, addressing health inequities and disparities and conveying partners to achieve mutual goals.

Provided by: SWACH is primarily funded through the Washington State Health Care Authority.

Partners: Our organization relies on partnerships with many different agencies, both public and private. In addition, we have key state partners including the Health Care Authority, Department of Health, Department of Social and Health Services, Managed Care Organizations, County governments and local elected officials

Funded by: SWACH receives most of our funding from CMS through the Washington State Health Care Authority via the Medicaid Transformation Project.

Regional availability: Our region is one of nine ACH's in the state. We support communities in Klickitat, Skamania and Clark counties in the southwest region.

Targeted patient populations: Our target population is Medicaid beneficiaries and particularly those beneficiaries, groups and communities who have experienced socioeconomic disadvantages or historical injustices related to poverty, ethnicity, race, tribal affiliation, age, gender, education, disability, or minority status. Individuals with Opioid Use Disorder, individuals with chronic health conditions and those transitioning from hospitals back to the community are targeted populations many of our projects are also focused on.

Timeframe: Our organization will receive resources from the HCA from 2017-2021 for the Medicaid Transformation Project, although this effort does not represent all future ACH activities

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