



A Framework for Implementation of Washington's Integrated Care Assessment

Phase II Summary Report

Prepared by HealthierHere on behalf of the Clinical Integration Assessment
Workgroup

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Introduction

Since 2014, Washington State has been transitioning to fully integrated managed care for physical and behavioral health care (including mental health and substance use treatment) within the Medicaid program. By January 1, 2020, the state completed financial integration for most Medicaid members (certain subgroups remain in fee for service for some or all of their care) across the state. With the implementation of the 1115 Medicaid waiver, the state also increased focus and support of clinical integration at the point of care. Through integration, the state seeks to support whole-person integrated care and hopes to reduce the complexity of separate systems for physical and behavioral health; to improve provider communication and coordination and reduce unnecessary duplication of services; to expand access to behavioral health services; and to link clients with community services such as housing and employment support.

A standardized clinical integration assessment tool and process that assesses the level of integration of physical and behavioral health providers is needed to support the priorities of Washington's Health Care Authority (HCA) to increase equitable access to whole person, integrated care for individuals enrolled in Medicaid. With a standardized assessment and process, there will be opportunities to:

- Develop an improvement roadmap for practices to advance integration.
- Reduce provider administrative burden by minimizing duplication.
- Consistently and uniformly understand the level of, and progress toward, bidirectional clinical integration within behavioral health and primary care outpatient practices and its subsequent impact on health outcomes.

To address this need, an Integration Assessment Workgroup ("Workgroup") was formed in mid-2020 and includes representatives from HCA, all five Medicaid Managed Care Organizations (MCOs), and three representatives of the Accountable Communities of Health (ACHs). The purpose of the Workgroup is to:

- Identify a common tool to use statewide to assess provider level of integration.
- Define a standardized process/logistics around the assessment of clinical integration to streamline data collection and reduce duplication, including roles and responsibilities of various partners (HCA, ACHs, MCOs).
- Determine how the data and information that results from the assessment will be utilized.
- Recommend a sustainable mechanism for ongoing assessment and continuous quality improvement.

The Workgroup has been meeting, on average, twice a month and, in the fall of 2020, identified and selected a standardized, evidence-based provider self-assessment tool that could be used to assess the level of integrated care in primary and behavioral healthcare settings across the state. The Workgroup selected a tool developed in New York by Henry Chung, MD, which has versions developed specifically for Behavioral Health and Primary Care settings: *General Health in BH*

Settings Framework and the *Continuum-Based Behavioral Health Integration Framework for Primary Care Setting*.¹ This tool is available in the public domain and there are no fees associated with its use.

With a potential tool identified, the HCA provided funding for two phases of work to advance testing of the tool and for the development of implementation strategies and recommendations. Phase I was funded from February 24 through June 30, 2021, and led by HealthierHere, the Accountable Community of Health for King County. In Phase I, HealthierHere piloted each version of the tool with a sample of providers from across the state. These sites included three primary care clinics (one of which was a pediatric care clinic) and three behavioral health agencies, including one provider that delivers Medication for Opioid Use Disorder (MOUD). Results of the pilot project provided significant insights into provider needs and capacity to complete the tool and its use to inform quality improvement, as well as mechanisms for distribution, data collection, analysis, and reporting.

While the pilot testing was underway, the Integration Assessment Workgroup began to develop an implementation framework to address logistics and roles and responsibilities for statewide implementation of the standardized assessment tool among HCA, MCOs, ACHs, and other stakeholders. The Workgroup submitted initial recommendations to HCA in June 2021 for a statewide framework for implementation, including input on who should disseminate the tool, who should collect the data and synthesize it, what the data would be used for, and a high-level description of the types of training and technical assistance that would be needed for implementation. A copy of the full report and recommendations from Phase I can be requested by emailing info@healthierhere.org.

Building off the work of Phase I and the recommendations from the Workgroup, HCA funded a Phase II project from July 1, 2021, through September 30, 2021. In Phase II, HealthierHere was contracted to engage providers, across the state (including pediatric practices, FQHCs/primary care, and behavioral health providers (including mental health and substance use disorder providers)), their representative associations (i.e., WSHA, WSMA, Washington Council for Behavioral Health), and other key stakeholder organizations (i.e., Bree Collaborative, UW AIMS Center, etc.) to provide guidance to the Integration Assessment Workgroup. Their input informed the Workgroup's efforts to:

- Understand the unique needs and requirements for implementation of the standardized assessment tool by provider type.
- Develop an Implementation Roadmap (see below) that would provide recommendations for how to phase in the implementation of the tool, building off current strengths and infrastructure in the system as well as information gathered in the Phase I project.
- Determine milestones and timelines to move towards implementation at full scale.

¹ https://www.thenationalcouncil.org/wp-content/uploads/2020/08/GHI-Framework-Issue-Brief_FINALFORPUBLICATION_7.24.20.pdf?dof=375ateTbd56

Input and feedback from these groups is described below and was used to inform the recommendations in this report.

Phase II also required the Workgroup to develop an Implementation Roadmap (see below) to include key milestones and associated timelines to advance implementation of the new tool and process beginning in 2022. This report is the culmination of the Phase II work and is submitted to HCA for consideration and recommendations for how to move forward.

In addition, as part of the communications efforts described below, the Integration Assessment Workgroup recommends that the HCA brand this effort for ease of reference. The Workgroup selected the *Washington Integrated Care Assessment (WA-ICA)* as the title of the undertaking.

Finally, to ensure clarity of its vision and to guide its work, the Workgroup articulated that the purpose of the WA-ICA is to:

- Assess the level of, and progress toward, bidirectional clinical integration within behavioral health and primary care outpatient practices.
- Serve as a quality improvement roadmap for practices to advance integration.
- Improve patient/client outcomes.
- Provide regional and statewide data to drive policy/funding decisions.

As the Workgroup moved through Phase II of the work, they identified four priorities: 1) phasing of the rollout of the tool; 2) scoring of the tool and reports that could be generated; 3) principles around data use and the flow of data; and 4) provider engagement. The sections below describe the results and recommendations of the Workgroup and the related sub-workgroups related to these four priority areas.

Phasing

With the significant number of provider sites estimated across the state (approximately 5,600 based on preliminary data), the Workgroup determined it would be necessary to take a phased approach to implementation to ensure sufficient infrastructure and capacity is developed and provider cohorts could be given the level of attention needed to transition to the new WA-ICA. The Workgroup also wanted to balance that with making sure implementation could begin as quickly as possible. The Workgroup formed a Phasing Committee to develop recommendations for phasing implementation statewide, beginning in July 2022. The Phasing Committee included representatives from MCOs, ACHs, and HCA.²

In developing recommendations for the implementation roll out, the Phasing Committee considered the following:

² Phasing Committee members included: Sylvia Gil, Community Health Plan of Washington; Jennie Harvell, HCA; Susan McLaughlin, HealthierHere; and Colette Rush, HCA.

Total number of outpatient primary care and behavioral health providers

- One of the first steps required to determine specifically which providers will be assessed is to determine the 'N' of all outpatient primary care and behavioral health organizations and how many sites those organizations have serving individuals enrolled in Medicaid.
- Early estimates indicate there are approximately 5,600 outpatient primary care and behavioral health sites serving Medicaid clients in Washington State.
- A more refined estimate is needed of the number of Medicaid participating out-patient primary care and behavioral health practices, including practices that serve Medicaid/Apple Health enrolled children, youth, and adults. Towards that end, HCA will pull Medicaid claims and encounter data to determine:
 - The number and location of Medicaid out-patient primary care and behavioral health provider sites
 - For the most recent six-month period for which data is available:
 - Average number of Medicaid claims per month per site
 - Average unduplicated Medicaid beneficiaries per month per site
- Using this data, the Workgroup will be able to make recommendations regarding provider practice participation/implementation of the WA-ICA based on the number of Medicaid clients treated by the practice per month. The Workgroup will consider the use of different thresholds by provider type (e.g., hospital based primary care, community health centers, community behavioral health agencies and stand-alone substance use disorder treatment providers).

Implementation roll out that builds off current strengths and infrastructure

- Implementation should build off existing infrastructure and strengths of the system in assessing provider level of integration including ACHs and MCOs.
- Implementation should streamline for efficiencies wherever possible.
- The effort will require a partnership between the MCOs and ACHs as both types of entities offer strengths, expertise, and some existing infrastructure to support the work.

Sufficient resources are needed to ensure success

- Sufficient resources will be needed to support implementation.
- The primary identified funding sources to support implementation are the current 1115 waiver and the waiver extension and renewal that are expected to begin respectively in January 2022 and in January 2023.
- Medicaid MCOs and ACHs will be partners in implementation and are expected to participate and support the ongoing assessment process.
- The Workgroup will continue to work in partnership with HCA to define specific roles and responsibilities of MCOs and ACHs, and identify refinements needed over time.

Implementation of the WA-ICA will begin in 2022 and align across the state

- HealthierHere conducted a survey of ACHs and MCOs to obtain more information about how integration assessment data is currently being collected across the state. Please see Appendix A for a summary and excerpts of the ACH/MCO data collection survey.
- All ACHs have been collecting integration assessment data at least twice a year using the Maine Health Assessment Foundation (MeHAF) tool as part of Project 2A: Bidirectional Integration of Physical and Behavioral Health within the 1115 Medicaid waiver. During the pandemic, HCA made collection of MeHAF data optional and there is variability in how ACHs proceeded: some ACHs continued regular data collection on all eligible providers; some modified their data collection and/or collected data for fewer providers; some discontinued data collection all together.
- MCOs have also been required to assess level of integration within their current Medicaid provider networks using a tool of their choice. Each MCO has approached the assessment differently and each uses a different tool and method to complete the required assessment.
- ACHs and MCOs will stop using the MeHAF and/or other identified tools by the end of 2021 and transition to the new WA-ICA beginning in January 2022.
- The data collection survey also indicated significant variability in when assessment data is collected. Ending the use of other tools in 2021 and the phased approach described below will allow for alignment of a single data collection period for all providers across the state, ensuring a full state perspective is achieved in a timely way.

Phasing Recommendations

Based on the above considerations, the Phasing Committee makes the following recommendations:

Recommendation #1: Begin phasing in July 2022 moving to 100% of eligible providers by July 2024.

It is recommended that the state begin implementation in July 2022 with assessment of Cohort 1. A new cohort of providers would be added every six months, achieving full implementation of all sites by July 2024 as follows:

- | | |
|----------------|-------------------------------------|
| • July 2022 | Cohort 1 |
| • January 2023 | Cohort 2 |
| • July 2023 | Cohort 3 and Cohort 1 |
| • January 2024 | Cohort 4 and Cohort 2 |
| • July 2024 | Cohort 5 and Cohorts 1, 2, 3, and 4 |

Once all eligible providers have completed the WA-ICA at least once, it is recommended that assessments occur annually. The Workgroup also recommends that provider assessment be aligned to a single data collection period annually, occurring in Q3 each year (July – September). This will allow a full statewide assessment and reporting in a consistent and timely manner. HCA may want to consider the possibility of an interim six-month progress report (not completing the full

assessment, but an opportunity for providers to report on progress on their action plan). This consideration requires provider input to determine what would be most helpful to provider organizations in understanding progress, balanced with the burden of reporting requirement. This is a consideration that could evolve over time.

Based on the above phased implementation schedule, each cohort is expected to include approximately 20% of the identified Medicaid participating out-patient primary care and behavioral health providers OR could start with smaller cohorts early on and increase the size of subsequent cohorts as process and efficiencies are developed over time. Furthermore, under this model, 100% of all providers eligible and meeting criteria for inclusion in the WA-ICA will be included by July 2024.

Recommendation #2: Define specific cohorts.

HCA, in collaboration with MCOs and ACHs, will identify the Medicaid outpatient primary care and behavioral health provider sites to complete/submit the integration assessment tool (see data pull described above under considerations). Determining the cohorts and timing will need to involve a process that includes consideration of:

- Previous experience completing the MeHAF/other clinical integration assessment tool.
- Number of Medicaid clients served (minimum thresholds TBD and may differ by provider type).
- Location of providers in regions across the state (ensuring a balance in regions across the state to balance burden).
- Provider type (ensuring different provider types are rolled into implementation in an equitable way).

Applying the above criteria, Cohort 1 would include all current outpatient primary care and behavioral health sites that have completed the MeHAF as part of the current 1115 waiver in partnership with ACHs plus any additional providers that have completed a formal integration assessment with the MCOs. Based on available data, Cohort 1 would include approximately 20% of provider sites across the state. Cohorts 2 – 5 would subsequently include approximately 20% additional providers, utilizing the criteria described above and considering readiness and regional capacity, with Cohort 3 expected to include the primary care practices electing to participate in the new multi-payer primary care initiative.³

Recommendation #3: Communicate with and engage providers throughout implementation.

HCA, in collaboration with MCOs and ACHs, should continue to develop and implement a statewide communications strategy to share implementation planning for the WA-ICA, ensure providers understand the “what, why, and how,” and to build momentum for the opportunity. In addition, in advance of each data collection period, MCOs and ACHs will collaboratively communicate with and

³ It may be that some practices participating in the multi-payer primary care initiative could be in an earlier cohort because they have been completing the MeHAF or working with MCOs on other assessments.

engage providers targeted for inclusion in the upcoming cohort to increase provider awareness of the WA-ICA; to outline the completion and submission requirements/timelines; and to reinforce the value of the assessment process including development of and support for a provider action plan to advance clinical integration. MCOs and ACHs will work together to ensure all providers in a cohort are engaged and reached in an efficient way that ensures shared responsibility and reduces duplication of effort.

Scoring and Reports

The Integration Assessment Workgroup determined that another component of implementation that required prioritization was determining how the tool would be scored and what reports would be generated. They formed a Scoring Committee to consider how to score the WA-ICA to best inform the analyses and to determine the reports that could be created to serve the needs of various stakeholders. The Scoring Committee addressed the following:

- Guiding principles for scoring and use of data (see Data section below)
- Scoring methodology
- Data/information that could be available from the tool and examples of types of reports
- Variables for identifying similar practice sites.

Members of the Phasing Committee included representatives from MCOs, ACHs, HCA and other key stakeholder organizations.⁴ The Scoring Committee also shared their recommendations with representatives of five of the six provider pilot sites for feedback. That group s the methodology, with the caveat that it must be accompanied by clear messaging around the purpose of the assessment and how results would be interpreted and shared. In short, how the use of the tool and related findings are framed is critical.

The HCA lead of the Scoring Committee consulted with Dr. Henry Chung, the developer of the tool, to learn how New York had scored and used the tool. Dr. Chung referred to the report he and colleagues had prepared [Evaluation of a Continuum-Based Behavioral Health Integration Framework Among Small Primary Care Practices in New York State, Practice and Policy Findings and Recommendations](#), which describes an approach for scoring and analyses. Dr. Chung shared that the same approach described in the report is being used in the General Health Integration Learning Collaborative, a national initiative sponsored by the National Council for Behavioral Health and the Center of Excellence for Integrated Health Solutions, that began in early 2021 and is ongoing for participating Certified Community Behavioral Health Clinics (CCBHCs).

In addition to scoring, the full Workgroup also considered the various reports that could be generated from the data. To understand the type of information and data that might be helpful, in

⁴ Scoring Committee members included: Laurel Avila, Greater Columbia ACH (GCACH); Sara Barker, UW AIMS Center; Amy Etzel, BREE Collaborative; Brittany FoxStading, GCACH; Jennie Harvell, HCA; Nyka Osteen, North Sound ACH; Colette Rush, HCA; Jason Russell, GCACH; Martin Sanchez, GCACH; Sam Werdel, GCACH; and Sharon Williams, United Health Care.

August, each organization represented on the Workgroup completed a survey sharing the types of information their organization was interested in seeing and why. The Workgroup used the results of the survey both to determine the types of reports that could be generated as well as the data flow (see Data section).

Scoring and Reporting Recommendations

Based on the work of the Scoring Committee, the Workgroup makes the following recommendations:

Recommendation #4: Adopt the methods for scoring, analyses, and reports from New York.

This approach will support practices in their quality improvement efforts and provide stakeholders with information about trends and progress in advancing integration as well as identifying significant challenges/barriers. Using this scoring methodology would also align Washington with national initiatives (see above) and would contribute to the body of evidence about the effectiveness of the tools.

Recommendation #5: Share individual site data with entities providing coaching support and use de-identified data to monitor progress by region and statewide.

Practice sites and those providing technical assistance and coaching will need access to the individual site data to inform opportunities for improvement and track progress over time at the site level. Aggregated de-identified data should be used to understand how groups of similar practice sites are doing within ACH regions, MCO provider networks, and as statewide summaries.

Recommendation #6: Add supplemental questions to better understand provider demographics and variability.

Adding supplemental questions to the assessment will help all stakeholders better understand low and high scores, internal and external barriers, and considerations related to infrastructure and readiness (e.g., leadership engagement, technology). Additional practice demographic questions describing each practice would also be added to identify/group similar practices (e.g., type of organization, patient population served, size), when appropriate, for reporting purposes.

Recommendation #7: Assign unweighted scores across the levels of integration.

While the framework was not initially designed to result in a calculated global score, similar frameworks have used such scoring methodologies (e.g., MeHAF, PCMH-A). A global score could range from a low of 13 to a maximum of 52 to summarize all points across the levels of integration for an individual practice, or as an average or median of aggregated data.

Data

The Workgroup discussed the use and flow of data throughout the course of implementation planning. In this phase of work, the Workgroup had two key goals:

1. Define a standardized process/logistics around the assessment of integration to streamline data collection and reduce duplication, including roles and responsibilities of various partners (HCA, ACHs, MCOs); and
2. Determine how the data and information that results from the assessment will be utilized.

While specific roles and responsibilities of HCA, ACHs and MCOs will be addressed in the coming quarter, the Workgroup made good progress on the use and flow of data.

Recommendation #8: Utilize a set of principles to govern the use and flow of data.

The Workgroup agreed to the following principles for the use and flow of data:

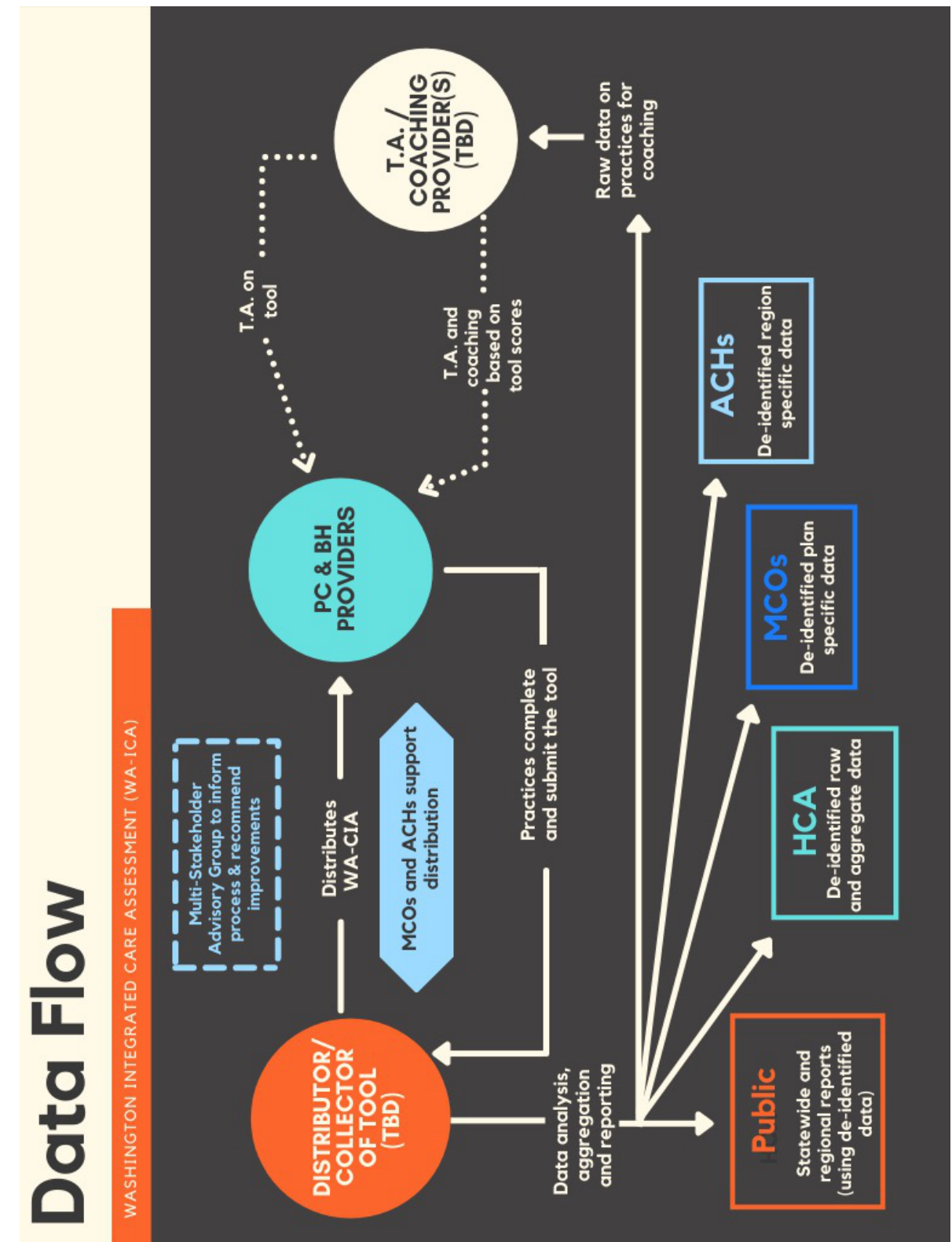
There will be transparency about how information and data gathered through the WA-ICA will be used.

ACHs, MCOs, and the HCA will receive only the data that each entity needs to fulfill their respective responsibilities.

- Data about specific providers will be used to provide training and technical assistance to individual practices to advance the delivery of integrated care and improve patient outcomes.
- There is an expectation that over time practices will make progress on integration.
- De-identified provider-level data will be utilized to assess progress towards clinical integration and monitor regional performance.
- Aggregated data will be utilized to identify statewide improvement strategies and ensure resources are targeted where they are needed most.
- Aggregated data also may be utilized in conjunction with alternative payment methodologies, to align with other HCA initiatives, and inform needed policy changes to advance integration statewide.
- The results of the assessment may enhance a practice’s ability to take advantage of increased referrals, alternative payment models, and other opportunities for practices with advanced integration.
- Provider level data will not be publicly disclosed without provider permission.
- Data to be collected from providers includes data from the WA-ICA, supplemented with information on barriers to integration, and provider demographic data (e.g., practice type, location, size).
- Analyses of the data will include comparisons among “like” provider types and regional or statewide benchmarking, including areas of success/best practices and opportunities for improvement.

Recommendation #9: Be transparent about which entities will see what type of data and clarify how data will be utilized.

The Workgroup created the diagram on the following page to illustrate how data would flow and be used.



Recommendation #10: Clearly delineate the different types of reports possible, including whether/how “like” practices might be compared using de-identified data.

The Scoring Committee made the following recommendations on the potential use of information garnered from the WA-ICA:

- Data about individual practice sites could be used to:
 - Compare outcomes over time to inform quality improvement efforts.
 - Assist teams (at the practice level) in developing action plans.
 - Identify domains/subdomains with significant internal or external challenges/barriers that practice’s require support with, or best practices that can be shared through learning collaboratives.
 - Identify where coaching/technical support could be/has been helpful.
- Aggregated data should be used to describe how a group of similar practice sites are doing including:
 - Global scores ranging from high to low, and median scores.
 - Domains/subdomains with highest/lowest scores.
 - Comparisons of baseline to subsequent assessment scores including:
 - Number of practice sites at preliminary, intermediate, and advanced levels across subdomains.
 - Number of practice sites advancing at least one stage of integration across subdomains.
 - Sub-domains with the highest percentage of practice sites reporting improvement.
 - Sub-domains in which practices reported the least advancement.
 - Other reports as defined, as stakeholders gain experience and identify additional information that is needed.

Recommendation #11: Be intentional about comparing like practices (using de-identified data) to ensure comparisons are valid.

As stated above, aggregate data could be used to describe how a group of similar practice sites are doing within regions, networks, and the state. The Scoring Committee *began* the process of highlighting potential variables that could be used to identify similar practices including:

- Type of providers
 - BH (MH/SUD, MH only, SUD Only)
 - Physical Health (PH) (pediatric, adult, FQHC, RHC clinics, CAH clinics)
 - Practices with BH/PH co-location (e.g., certified BHAs and FQHCs)
- Size of practice site (# of providers = <5; 5-10; >10)
- Number of staff including support staff
- Number of chronic care vs acute care visits and the number of each per day
- Mix of payment types – alternate payment models, % Medicaid, Medicare, uninsured, private, capitated, and fee-for-service payment
- Cultural and linguistic demographics
- Percentage of in-person or virtual visits
- Experience with continuum-based tools

- Number of years working on BH/PH integration
- Rural health clinics
- Medical shortage designations
- Health Professional Shortage Area (HPSA) Designation
- Medically Underserved Area (MUA) and Population Designations
- Geography contributors (e.g., distances traveled, access to care issues)
- SDoH lack of referral options

In the upcoming quarter, the Workgroup will review and refine the list of criteria above.

Provider Input and Communications

Along with considerations of phasing, scoring and data collection and sharing, a critical aspect of the work from July through September was engagement with providers to get input about the implementation of the WA-ICA and to inform communication materials. The Communications Committee⁵ met consistently to determine how to reach providers, to discuss mechanisms for communications and to work together on drafting materials. Members of the Communications Committee included representation from ACHs, MCOs and HCA. The Communications Workplan for Phase II is attached as Appendix B.

Provider Advisory Group

A central strategy to get provider input was assembling a Provider Advisory Group (PAG). Membership included staff and leadership from provider associations and representatives from each of the six spring 2021 pilot sites (see Appendix C). The PAG’s charge was the following:

The Provider Advisory Group (PAG) will provide input to inform the implementation of a statewide integration assessment tool. The PAG’s input will go to the Integration Assessment Workgroup, which includes representatives from HCA, MCOs and ACHs. Specifically, the PAG will offer a provider perspective that informs an implementation roadmap. In addition, the PAG will suggest effective mechanisms and venues to communicate with providers about the tool – both to inform implementation and to spread the word about the tool.

The PAG met three times and provided important feedback and input into the implementation roadmap and communications strategy for the WA-ICA. Below is a high-level summary of what the group shared over the three meetings:

- Early and clear communication with providers is critical.
- Expectations of providers must be well-defined.
- Providers have to understand that the new tool will replace those that preceded it (from ACHs and MCOs).

⁵ Communications Committee members included Liz Baxter, North Sound ACH; Vicki Evans, Molina Healthcare; Sylvia Gil, Community Health Network of Washington; Michael McKee, HealthierHere; Colette Rush, HCA; and Caitlin Safford, Amerigroup.

- Providers should see the assessment process as a learning tool and understand how completing the tool will benefit their practice and patients.
- The roll out has to be thoughtful.
- Clarity about roles and responsibilities is important (e.g., who will administer the tool, who will provide technical assistance and coaching).
- Transparency of who will see the data (identified and de-identified) and how it will be used is key.
- Training and technical assistance should be personalized as much as possible.
 - Distinguish between TA to complete the tool and TA to advance integration.
 - Offer a menu of opportunities, including one-on-one TA; learning collaboratives; office hours; webinars; case studies, peer support. From intensive (individualized coaching) to minimal (FAQs).
- If there are shared statewide goals to demonstrate progress across the state, focus on goals that are comparable across different types of practices; continue to emphasize learning and progress for individual practices.
- Be mindful of comparing “like” practices because there are many variables that differentiate provider sites including size, geography, patient demographics; mix of payment types; number of providers in the practice, experience with integration; etc.
- Consider hosting opportunities to learn from peers and let the providers/practices decide which peer group best suits them. For example, there could be a peer learning network for rural providers, pediatric providers, primary care practices, etc.
- Use a variety of ways to reach providers and communicate about the WA-ICA opportunity and how it may benefit their progress toward integration, including through associations, conferences, office hours.
 - Sample opportunities for connecting with providers include the monthly meetings of the Washington Council on Behavioral Health and the Association for Alcoholism and Addiction Programs; the American Academy of Pediatrics conference in April 2022 and quarterly meetings for behavioral health providers convened by the Washington Association for Community Health.
 - Monthly office hours or webinars open to all and advertised with associations is also a promising approach.

At their third meeting, the PAG provided feedback on the data principles and flow diagram, as well as the one-pager and FAQ. Their input included the following:

- The principles are good, and the data flow makes sense.
 - Naming the entities that will distribute and collect the assessment and do TA and coaching would be very helpful.
 - Be clear about who will see what kind of data.
- For both the one-pager and FAQ:
 - Be clear on requirements.
 - Add as much detail as possible on timeline.

- Additional provider feedback included:
 - Need to understand if PEBB/SEBB and Cascade Care will be engaged with this work.
 - Make sure this work is tied to VBP efforts at HCA.
 - Getting endorsements from associations is important.

Additional meetings with stakeholders

As reported in the Phase I report, the Communications Committee had several meetings with associations to share information about the tool and process. In Phase II, the Committee had a well-attended informational meeting with representatives from Comagine, the Bree Collaborative, the Behavioral Health Institute, AIMS Center, CoLAB, and the Evidence Based Practice Institute to outline the Workgroup’s process to date, provide detail about the tool that was selected and why, and to share next steps. Communications Committee members also individually connected with the Washington Chapter of the American Academy of Pediatrics (to discuss potential alterations to the tool for pediatric practices), the Washington State Medical Association (to bring them up to speed on the tool and process), and the Washington Association for Community Health (to provide additional context and support for the work).

Development of communication materials

The other major task for the Communications Committee was creating content to share with providers. As indicated above, the Committee drafted a one-pager and FAQ. The documents were reviewed and revised by the Communications Committee, the full Workgroup, and the Provider Advisory Group. The Committee also created, and is in the process of revising, an introductory slide deck that can be used for presentations and webinars. For example, Caitlin Safford of Amerigroup used the slide deck as a basis for her presentation about the WA-ICA at the recent State of Reform conference.

The most recent drafts of the one-pager and FAQ are attached as Appendix D and E, respectively. Once finalized, all communications materials will be posted on a website that HCA will create and host. The website will also include this report as well as the Phase I report, *A Framework for Implementation of a Statewide Clinical Integration Assessment Tool: Phase I Summary Report*, and will have an email address where interested parties can submit questions.

Throughout the last six months, the Workgroup discussed what to name the tool since the formal name is long and not particularly descriptive. As described in the introduction, the Communications Committee recommended to name the *approach* rather than the *tool*. In addition, while there was feedback that “assessment” felt like providers were being graded, the Committee felt that it was an important descriptor because the tool is meant to facilitate progress on integration. Finally, there was agreement that “integrated care” should be included.

Future plans for communications

Ongoing communications with providers will be critical. This includes refining communications

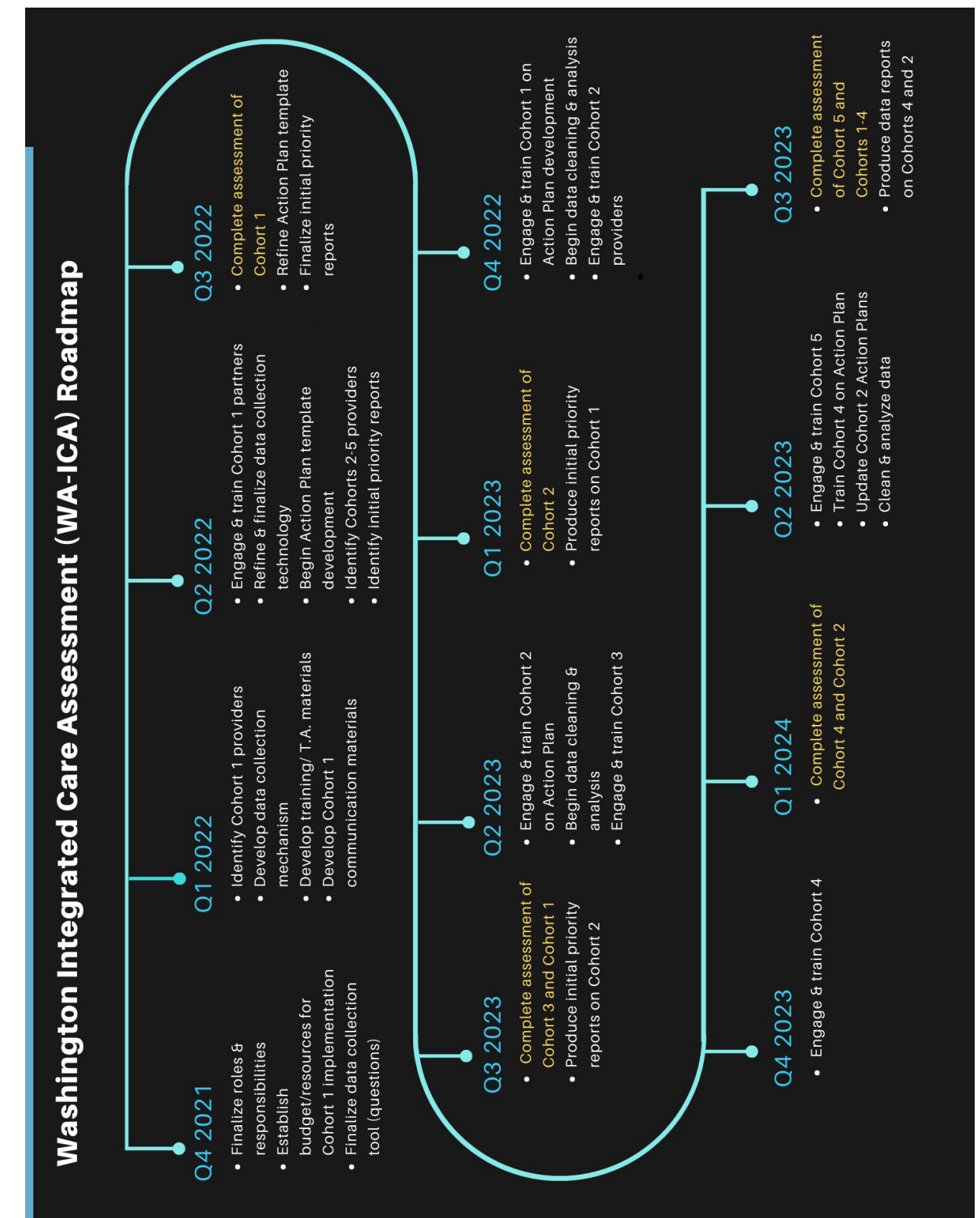
materials as additional decisions are made; implementing ongoing outreach to providers, such as attendance at conferences and monthly information sessions; continuing HCA's engagement with tribal partners; and connecting with related groups to keep them informed.

One upcoming opportunity will be a session focused on the WA-ICA at the HCA/ACH 2021 Learning Symposium. Panelists will include a provider who piloted the tool and the three tri-chairs of the Workgroup, representing HCA, an MCO and an ACH.

Implementation Roadmap

Based on Workgroup discussions over the last six months, an Implementation Roadmap was developed to provide a pathway to achieving statewide assessment of provider level of integration and accompanying training, technical assistance, and practice coaching to support primary care and behavioral health providers in their journey toward integrated care and ultimately improved outcomes for the clients they serve. The roadmap includes short term, mid-term, and longer-term activities for what the statewide infrastructure and capacity could look like and immediate steps over the next year to advance implementation. The implementation roadmap builds off existing infrastructure and strengths, streamlining where possible for efficiencies.

The visuals on the following pages show both an overarching roadmap, as well as a more detailed work plan for 2021-22.



Washington Integrated Care Assessment: 2021-22 Implementation Roadmap

2021 Q3 (by Sept. 30th) Key Deliverables

<ul style="list-style-type: none"> Outline Implementation Roadmap <i>Status: Complete</i>
<ul style="list-style-type: none"> Determine phasing approach to implementation that specifies how and when provider cohorts will be rolled into implementation (phasing of implementation), including frequency and timing of assessments <i>Status: Complete</i>
<ul style="list-style-type: none"> Develop and implement provider communications and input plan <i>Status: Complete</i>
<ul style="list-style-type: none"> Convene Provider Advisory Group <i>Status: Complete</i>
<ul style="list-style-type: none"> Develop provider communications materials, including one-pager, FAQs, and slide deck <i>Status: Complete</i>
<ul style="list-style-type: none"> Determine data needs, uses and flow <i>Status: Complete</i>
<ul style="list-style-type: none"> Determine scoring for tool <i>Status: Complete</i>

2021 Q4 (by Dec. 31st) Key Deliverables

<ul style="list-style-type: none"> Continue provider outreach and gathering provider input through presentations at provider meetings; open office hours
<ul style="list-style-type: none"> Set up simple HCA website for communications materials; to have a place for people to ask questions; include contact email
<ul style="list-style-type: none"> Determine role and qualifications/requirements for central entity/entities doing tool distribution, collection, and data analysis
<ul style="list-style-type: none"> Adapt tool, including adaptations based on pilot partner feedback and adaptation for pediatric and SUD practices
<ul style="list-style-type: none"> Draft Implementation Guide and accompanying FAQ Guide to assist practices completing the tool
<ul style="list-style-type: none"> Identify recommended technical assistance for tool completion, including what entity(ies) will provide that assistance
<ul style="list-style-type: none"> Determine process and requirements for selecting/identifying centralized entity/entities
<ul style="list-style-type: none"> Determine roles/ responsibilities for HCA, ACHs and MCOs, including TA, distribution, and evaluation, etc.
<ul style="list-style-type: none"> Identify and develop needed legal agreements amongst involved parties (MOUs, contracts, DSAs, etc.)
<ul style="list-style-type: none"> Develop training/implementation plan for Cohort 1 rollout
<ul style="list-style-type: none"> Set provider participation requirements, including which tool should be used for various types of integrated practices (How will the tool be completed for practices that have both an integrated program for certain patients/conditions and refer out to services for other patients/conditions?)

2022 Q1 (by March 31st) Key Deliverables

<ul style="list-style-type: none"> Synthesize and analyze provider input
<ul style="list-style-type: none"> Develop approach to comparing data from integrated assessment tool to previous tools
<ul style="list-style-type: none"> Identify additional questions to be included with the tool for data collection purposes (e.g., leadership, equity)
<ul style="list-style-type: none"> Distribute communication and implementation strategy for Cohort 1 practices
<ul style="list-style-type: none"> Collect user feedback on Implementation Guide and FAQ Guide
<ul style="list-style-type: none"> Identify and/or develop resources to support training, technical assistance, and implementation of tool
<ul style="list-style-type: none"> Identify and/or develop resources and plan for coaching
<ul style="list-style-type: none"> Develop a technical assistance guide for providers of TA to utilize when coaching practices

2022 Q2 (by June 30th) Key Deliverables

<ul style="list-style-type: none"> Cohort 1 rollout
<ul style="list-style-type: none"> Develop and implement training for Cohort 1 providers
<ul style="list-style-type: none"> Edit and finalize Implementation Guide
<ul style="list-style-type: none"> Develop rules for assessment reporting / data sharing at state and regional levels
<ul style="list-style-type: none"> Develop approach to measuring clinic/agency progress and expectations for improvement
<ul style="list-style-type: none"> Develop approach to using organizational level data for continuous improvement
<ul style="list-style-type: none"> Identify tool submission process/platform for long term
<ul style="list-style-type: none"> Select centralized entity/entities to begin implementation

2022 Q3 (by Sept. 30th) Key Deliverables

<ul style="list-style-type: none"> Develop statewide/ regional improvement plans (recommended 2-3 focus areas)
<ul style="list-style-type: none"> Develop approach to measuring clinical outcomes/ patient improvement over time and connect to level of integration
<ul style="list-style-type: none"> Identify central entity/entities for long term distribution, collection, and analysis (procurement process or other)
<ul style="list-style-type: none"> Prepare for Cohort 2 roll out; participants in multi-payer primary care initiative

2022 Q4 (by Dec. 31st) Key Deliverables

<ul style="list-style-type: none"> Implement provider communication plan/ training for Cohort 2 rollout
<ul style="list-style-type: none"> Cohort 2 rollout

Summary and Next Steps

HCA, MCOs, and ACHs are committed to transforming care to a system that provides equitable access to whole person, integrated care that includes physical and behavioral health and ultimately oral health and social services, to keep all people in the state healthy and well. The Integration Assessment Workgroup has made significant progress over the past year in shaping a vision for a standardized statewide integration assessment process and pathways to move towards this goal. The recommendations in this Phase II report, coupled with the Phase I recommendations, provide a framework and implementation roadmap to transition to the new tool by July 2022. However, there is still much work to be done. Next steps for the WA-ICA include:

- HCA, ACHs, and MCOs will work collaboratively to identify additional resources to support the planning and implementation activities for the remainder of 2021.
- The Integration Assessment Workgroup will continue to advance the Implementation Roadmap activities as outlined above.
- HCA will work internally to provide data on Medicaid provider sites across Washington to determine the 'N' for data collection and inform the cohort groups 1 – 5.
- The Communications Committee will continue to develop and refine communications and provider engagement materials and support provider association and partner engagement in the planning and implementation strategy.
- HCA, ACHs, and MCOs will work collaboratively to further define roles and responsibilities for each group that includes roles and responsibilities for 2022, and how those roles and responsibilities will evolve over time.
- HCA will work with ACHs to determine resource needs and expectations in 2022 for implementation.
- The Workgroup will support HCA, upon request, to engage Tribal partners and obtain their input/feedback on the WA-ICA tools and assessment and reporting methodology.

There is promise in this complex and multi-faceted work. Through the implementation of a statewide assessment, Washington will move closer to its vision of whole-person integrated care. The Workgroup is grateful for the opportunity to co-create the WA-ICA with HCA, MCOs, ACHs, providers and other key stakeholders. All involved feel that it has been a positive collaborative experience, resulting in a stronger product and is a model that could be used with other statewide initiatives.

Appendices

- Appendix A: Summary and Excerpts from Integration Assessment Survey Results
- Appendix B: Communications Workplan
- Appendix C: Provider Advisory Group Members
- Appendix D: One-pager
- Appendix E: FAQ

Appendix A: Summary and Excerpts from Integration Assessment Survey Results

Summary and Excerpts ACH and MCO Integration Assessment Survey Results August 2021

All ACHs (9) and MCOs (5) responded to the survey.

Key takeaways

- The use of integration assessments and the scale of efforts varies significantly among ACHs and MCOs.
 - Some ACHs report large numbers of reporting sites (dozens per sector), other ACHs just have a handful of sites in each sector. On the low end, one ACH has around 10 total reporting sites, on the high end it's close to 100.
 - Except for two MCOs, the use of regular integration assessments is largely an ACH activity.
- Each ACH is assessing partners at different times so it may take effort to get all partners across the state on the same reporting cycle for the new integration assessment.
- Use of financial incentives to complete an integration assessment is done by ACHs only. Fifty-five percent of ACHs are providing an incentive.
- Two ACHs have discontinued use of the MeHAF after HCA made it optional in 2020.
- One ACH only required contracted behavioral health providers to complete the MeHAF, not primary care partners.
- The provision of training, TA and practice coaching to support integration assessments is mixed. Forty-four percent of ACHs provide this support to partners (largely through contractors) and 60% of MCOs do, largely offering in-house support and resources.
- ACHs articulated that continuing to implement integration assessments and offer training/TA to support those efforts will be contingent on sustainable funding sources after the current waiver expires.

Excerpted Questions and Summarized Responses

- **Do ACHs assess provider-level physical and behavioral health integration?**
 - 9/9 have assessed integration during the MTP
 - 7/9 currently assess integration
- **Do MCOs assess provider-level physical and behavioral health integration?**
 - 3/5 assess integration
- **Which tools are used by ACHs?**
 - 7/9 currently use MeHAF
 - Other tools mentioned: PCMCH-A, Traditions of Health model for tribal health providers, custom qualitative and quantitative data reports related to integration.
- **Which tools are used by MCOs?**
 - 0/5 use the MeHAF exclusively
 - MCOs that do assessments generally have customized tools
- **Do ACHs resource or incentivize completion of the assessment?**
 - 5/9 resource completion of the assessment
- **DO MCOs resource or incentivize completion of the assessment?**
 - 0/5 MCOs resource completion of an integrated care assessment

- **How often do ACHs assess integration?**
 - 8/9 assess (or previously assessed) on a semiannual basis
 - 1 assesses monthly and annually
- **How often do MCOs assess integration?**
 - 2/5 assess on an annual basis
- **When do ACHs currently conducting assessments assess integration?**
 - March and September for one cohort, July and January for the other
 - June and December
 - January and July
 - No standardized cycle
 - January and July
 - April and October
 - June and November
- **Do ACHs use the information gathered through the integration assessment to provide training, TA, and practice coaching to advance integration?**
 - 4/9 of the ACHs do this or have done this
 - 3/5 of the MCOs do this or have done this
- **Does your ACH currently plan to continue implementing integration assessments if the 1115 Waiver no longer requires it?**
 - 5/9 plan to continue the assessments

Appendix B: Communications Workplan

**Clinical Integration Assessment Tool Communications Plan
July 2021**

Goal

Secure robust provider engagement to gather input and share with providers that there will be new framework to advance integration beginning in mid-2022. This plan will evolve as we engage and are informed by the Provider Advisory Group (see below).

As we gather input, we will be clear about four questions:

1. What are we asking? (Clear questions)
2. Who are we asking? (Being mindful of demands on providers)
3. How are we asking? (Survey, focus groups, through associations, etc.)
4. When are we asking? (What are highest priority questions?)

Messaging

As we socialize and disseminate information about the statewide assessment, we need shared and consistent messaging. We will disseminate the following messages:

- A statewide clinical integration assessment tool will be implemented beginning in mid-2022 to both primary care and behavioral health providers.
- The tool has been chosen and piloted, with positive feedback from pilot providers.
- We are reaching out to providers and their associations to get insights into implementation and guidance on how to best share information about the new tool, including the rationale and anticipated outcomes.
- The goal for advancing this new framework is to have a consistent, statewide clinical integration assessment tool to:
 - Assess the level of bidirectional clinical integration within behavioral health and primary care outpatient practices;
 - Serve as a quality improvement roadmap for practices to advance integration
 - Improve patient/client outcomes; and
 - Provide regional and statewide data to drive policy/funding decisions.

Workplan and Timeline

Artemis Consulting and HealthierHere will provide assistance with all communications efforts.

Clinical Integration Assessment Tool Communications Plan

Activity	Description	Who	When
Communications planning and implementation	Ongoing planning for provider communications, including setting meetings for providers and the Provider Advisory Group; drafting agendas; reaching out to providers and those that represent them through appropriate channels.	Communications Committee	July-September
Development of communications materials	Develop and disseminate communications materials that inform primary care and behavioral health providers and their respective associations (i.e., WSHA, WSMA, WA BH Council, etc.) about the evolution of the Clinical Integration Assessment Tool, and the work and transition to statewide implementation.	Communications Committee and HCA Communications Team	July-September
Convening of Provider Advisory Group	Establish a Provider Advisory Group to inform the implementation of the tool and to provide insights on how to best share information about the tool with providers. The group will meet at least three times and will inform the evolution of this communications plan. The group will also suggest and provide avenues to reach providers.	Communications Committee	July-September
Meetings/office hours with other key stakeholders, as necessary	While meetings have already been held with provider associations, we will meet in July with Bree, BHI, Comagine, AIMS, CoLAB and EBPI – all important stakeholders in this work. We will set up meetings with other groups as necessary. Briefings will include the messaging outlined above as well as rationale for why this work was started, timing for key activities, and what support and engagement with providers is under consideration.	Communications Committee	July-August
Multi-modal strategies to reach providers	We will utilize multi-modal strategies that may include surveys, focus groups, stakeholder interviews, office hours, and webinars to obtain provider input/feedback into distribution and data collection and readiness for implementation, as well as to share information about the tool.	Communications Committee with support from Integration Assessment Workgroup	July-September
Tribal partners engagement	HCA will continue to keep tribal partners informed as the work progresses.	HCA	Ongoing
Assistance with communications planning and implementation	<ul style="list-style-type: none"> • Ongoing input to Communications Committee, including providing insights on key issues and decisions. • Introduce tool to as many impacted providers as possible. • Identify major provider concerns and include plans for addressing challenges in framework for implementation. • Keep other related groups informed of Workgroup's efforts. 	Integration Assessment Workgroup	July-September

Appendix C: Provider Advisory Group Members

Integration Assessment Workgroup
Provider Advisory Group
Summer 2021

Association Representatives	Organization
Ann Christian Joan Miller	Washington Council for Behavioral Health
Brooke Evans	Washington State Hospital Association
Linda Grant	Association of Alcoholism and Addiction Programs
Jennifer Hanscom Jeb Shepard	Washington State Medical Association
Bob Marsalli David Rodriguez Hannah Stanfield	Washington Association for Community Health
Elya Prystowsky	The Rural Collaborative
Sarah Rafton	Washington Chapter of the American Academy of Pediatrics
Representatives from Pilot Sites	
Nicoleta Alb	Sea Mar
Kris Atkisson	Valley Medical Center
Danika Gwinn	Quality Behavioral Health
Rick Levine	Skagit Pediatrics
Greg Kleiner	Consejo
Yuki Yang	Ideal Option

Appendix D: One-Pager

The Washington Integrated Care Assessment
DRAFT 9/19/21

Washington has been on a journey to integrate physical and behavioral health care since 2018. Through integration, the state seeks to support whole-person care and hopes to reduce the complexity of separate systems for physical and behavioral health; to improve provider communication and reduce unnecessary duplication of services; to expand access to behavioral health; and to link clients with community services such as housing and employment support.

Over the last few years, many practices have completed integration assessments, either through working with their local Accountable Community of Health (ACH) a Managed Care Organization (MCO), or because they wanted to better integrate clinical care. To support coordination, partners that include the Health Care Authority (HCA), MCOs and ACHs have been working together to identify a standard provider self-assessment of clinical integration. Statewide implementation of the tool will begin in 2022.

Washington Integrated Care Assessment Overview

The Washington Integrated Care Assessment (WA-ICA) is meant to:

- Assess the level of, and progress toward, bidirectional clinical integration within behavioral health and primary care outpatient practices;
- Serve as a quality improvement roadmap for practices to advance integration;
- Improve patient/client outcomes; and
- Provide regional and statewide data to drive policy/funding decisions.

The WA-ICA includes two companion tools tailored to [primary care](#) and [behavioral health](#) (mental health and substance use disorder) settings. The tools are designed to support clinical teams to review their practices and map progress along a continuum of clinical integration across a set of domains. The domains include the following:

- Screening, referral to care and follow up
- Ongoing care management
- Multi-disciplinary team (including patients) with dedicated time
- Self-management support adapted to patient
- Systematic quality improvement
- Linkages with community and social services

Rationale

With a standardized assessment, there will be opportunity to:

- Develop an improvement roadmap for practices to advance integration;
- Reduce provider administrative burden by minimizing duplication;
- Consistently and uniformly understand the level of, and progress toward, bidirectional clinical integration within behavioral health and primary care outpatient practices.

Implementation

Starting in mid-2022, primary care and behavioral health providers that have experience in completing the MeHAF (or similar integration assessment tools) will begin using the standardized tool. Subsequent cohorts of providers will be required to complete the tool in six-month increments. Practices will complete the assessment once a year. More details on the timeline for implementation will be shared later this year.

This initiative is sponsored by HCA, in partnership with Washington’s nine ACHs and five MCOs.

- **ACHs:** Better Health Together, Cascade Pacific Action Alliance, Elevate Health, Greater Columbia ACH, HealthierHere, North Central ACH, North Sound ACH, Olympic Community of Health, Southwest Washington ACH
- **MCOs:** Amerigroup, Community Health Plan of Washington, Coordinated Care of Washington, Molina Healthcare, United Healthcare

For more information, visit *TBD* and/or email *TBD*.

Appendix E: FAQ

The Washington Integrated Care Assessment *Frequently Asked Questions* *DRAFT 9/23/21*

How and why was the new Washington Integrated Care Assessment (WA-ICA) chosen?

As part of the transition to Integrated Managed Care and the Medicaid Transformation Project supported by the 1115 Medicaid Waiver, clinical practices across Washington State have been completing integration assessments for multiple stakeholders, often with different tools, and at inconsistent and potentially redundant frequencies. To address these issues, staff from the Health Care Authority (HCA), all five Managed Care Organizations (MCOs) and representatives from the Accountable Communities of Health (ACHs) convened a collaborative partnership in mid-2020 to:

- Identify a common tool to use statewide to assess provider level of integration;
- Define a standardized process/logistics around the assessment of integration to streamline data collection and reduce duplication, including roles and responsibilities of various partners (HCA, ACHs, MCOs);
- Determine how the data and information that results from the assessment will be utilized; and
- Recommend a sustainable mechanism for ongoing assessment and continuous quality improvement.

By utilizing one integration assessment, the state hopes to:

- Advance whole-person, Integrated care;
- Develop an improvement roadmap for practices to advance integration;
- Reduce provider administrative burden by minimizing duplication;
- Consistently and uniformly understand the level of, and progress toward, bidirectional clinical integration within behavioral health and primary care outpatient practices;
- Improve patient outcomes; and
- Provide regional and statewide data to drive policy and funding decisions.

Who selected the tool?

The Integration Assessment Workgroup (Workgroup) worked together for the last year to identify the new integration framework and to create an implementation plan to introduce it to practices. The Workgroup is making recommendations to the state around implementation, timelines, and key milestones for the effort. The Workgroup also is gathering input and sharing information with practices through a Provider Advisory Group and provider information sessions.

What tool is Washington planning to use to assess level of integration?

The Washington Integrated Care Assessment (WA-ICA) includes two companion tools tailored to [primary care](#) and [behavioral health](#) (mental health and substance use disorder) settings. The tools are designed to support clinical teams to review their practices and map progress along a continuum of clinical integration across a set of domains. The formal names of the tools are the [Continuum Based Framework for Behavioral Health Integration into Primary Care](#) and the [Continuum Based Framework for General Health Integration into Behavioral Health](#) (collectively called the Washington Integrated Care Assessment or WA-ICA).

In choosing the statewide integration roadmap, the Workgroup researched and compared multiple frameworks and tools and consulted with local and national experts to identify an assessment. The Workgroup chose the new tools because the framework:

- Is based on current research/testing in primary care and behavioral health settings (most tools have been developed for primary care settings only);

- Focuses on well-established integration elements, but is not overly complicated;
- Is applicable for practices new to integration as well practices that have been focused on integration for a number of years;
- Addresses equity, cultural differences, and Social Determinants of Health;
- Provides data to inform progress towards integration.

What will happen with the MeHAF, or another tool I was using with MCOs?

Practices that complete the WA-ICA will not have to fill out an additional integration framework/tool from ACHs or Medicaid MCOs. All nine ACHs and the five Apple Health MCOs have agreed to use the WA-ICA. The HCA, along with the ACHs and MCOs are working to integrate lessons learned from past assessments (i.e., MeHAF) into the new structure to ensure that the progress made toward integration can be accurately portrayed for all partners and providers.

Which practices are being asked to use this tool?

Primary care and behavioral health practices that participate in Apple Health will have the opportunity to complete the framework starting in mid-2022 with other practices phased in over time.

Is completing the integration assessment required?

The tool will ultimately be required of out-patient primary care and behavioral health providers that provide services to persons covered by Medicaid/Apple Health through contracts with MCOs. The tool will assist practices with understanding their level of integration and will serve as a roadmap for next steps along the integration continuum. Practices will be eligible for coaching support and technical assistance to help them make progress on integration.

How long does it take to complete the assessment tool and how often will I fill it out?

Practice sites are encouraged to convene a team with broad representation to complete the assessment to gather multiple perspectives. It should only take the team a few hours to complete the assessment. Practices will complete the tool once a year.

Who will see the results of my assessment? How will that information be used?

The framework is meant to be a learning tool for practices. Practices that complete the tool will be able to see their results immediately – both their strengths in integration as well as their challenges. Identifiable data about specific providers will be used to provide training and technical assistance to individual practices to advance the delivery of integrated care and improve patient outcomes.

De-identified aggregated data will be utilized to assess provider, regional, and state progress towards clinical integration and to monitor MCO and ACH performance. This data will assist the state to identify statewide improvement strategies and ensure resources are targeted where they are needed most.

Can I get help in completing the assessment tool?

An implementation guide with instructions about how to complete the tool will be available. In addition, practices will be able to attend office hours to ask questions. There will also be limited individual technical assistance available to assist with completion of the tool.

What happens after I complete the tool?

The framework is a learning tool for practices and will be accompanied by free technical assistance and coaching from a trusted entity to help practices improve.

Is there anything I have to do now to get ready?

Practices will be notified well in advance of when they will be asked to complete the assessment. Prior to filling out the roadmap, practices will have the opportunity to learn more about how to complete the tool through trainings and technical assistance, such as webinars, office hours and online tutorials.

How can I learn more? Who do I contact for more information?

TBD. In process.