Successful Practices in Accountable Care: Building Capacity to Support Accountable Care Efforts
Washington Association for Community Health

Organization Profile

**Name:** Washington Association for Community Health  
**Year of Incorporation:** 1985  
**Number of Health Center Members:** 27  
**Number of Health Center Member Sites:** Over 300  
**Number of Patients Served By Member Health Centers in 2018:** Over 1 Million  

**Key Member Service Demographics:** Member health centers served over 100,000 patients experiencing homelessness, 23,000 veterans, 280,000 patients in a language other than English, 59% of patients covered by Medicaid, and over 1 million dental care visits in 2018.

**Areas of focus:** The Washington Association for Community Health provides services to their members in three overarching categories (1) policy advocacy and implementation, (2) capacity building, and (3) convening community health centers.

**Mission:** To strengthen and advocate for Washington’s Community Health Centers as the build healthcare access, innovation, and value.

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### Introduction

Committed to building capacity among Health Centers in Washington State, the Washington Association for Community Health (“The Association”) has supported member health centers in transforming care for the over 1 million patients the health centers served in 2018. The Association’s capacity building efforts and the training and technical assistance through which capacity was built, focused on six key areas: (1) workforce development, (2) Institute for Rethinking Education & Careers in Healthcare (In-REACH) apprenticeships (a workforce development program which trains medical assistants), (3) outreach and enrollment, (4) practice transformation, (5) oral health, and (6) behavioral health. These key areas reflect the highest need of the member health centers and “enable community health centers to deliver effective, evidence-based care to (the) patients.” Through one-on-one coaching, group trainings, connection to industry experts and resources, collaborative process improvement, and facilitated peer discussions (leveraging The Association’s convening power), The Association demonstrates best practices in ever-changing times. In order to organize the many ways The Association supports health centers engaged in accountable care, this publication focuses on the three domains of NACHC’s Value Transformation Framework (Infrastructure, Care Delivery, and People). In doing so, organizations can consider the capacity needed to support health centers in the transformation from volume to value and have tangible examples of successful strategies plus a conceptual model in which to organize those examples.

The Value Transformation Framework, developed by NACHC’s Quality Center, is a conceptual model designed to help health centers transform from a volume-based, to a value-driven, model of care. It distills research and evidence-based practices into clear pathways for change. The Framework organizes health center systems into three domains – infrastructure, care delivery, and people—and 15 change areas. For more information about the Value Transformation Framework, please see: [http://www.nachc.org/clinical-matters/value-transformation-framework/](http://www.nachc.org/clinical-matters/value-transformation-framework/)
Infrastructure

The “Infrastructure” domain of NACHC’s Value Transformation Framework features five change areas: improvement strategy, health information technology, policy, payment, and cost. In the past few years, The Association has focused on key quality measures meant to impact the overall health of the population served by member health centers which illustrate the importance of the five change areas. The measures reflect Uniform Data System (UDS) and payment methodology priorities, and were ultimately self-selected to focus on by the health center members. The measures are focused on diabetes (comprehensive diabetes care - poor HbA1c control (>9%) and comprehensive diabetes care - blood pressure control (<140/90)), hypertension (controlling high blood pressure (<140/90)); and childhood immunization status (combo 10). By focusing on these measures, among the many different clinical measures and opportunities for quality improvement, The Association is able to “effectively and routinely measure and communicate information about the quality, value, and outcomes of the health care experience”. For example, in their work on Diabetes, the Association collaborated with the American Diabetes Association which led to 31 community health workers signing up to be Diabetes Ambassadors in their community. According to the American Diabetes Association, Diabetes Ambassadors “implement informational diabetes workshops and other educational initiatives that promote healthy eating, physical activity, and diabetes self-care in their communities and among their peers.” An increase in Diabetes Ambassadors has helped health centers in addressing diabetes care measures.

Key Quality Measures

1. Comprehensive diabetes care - poor HbA1c control (>9%)
2. Comprehensive diabetes care - blood pressure control (<140/90)
3. Controlling high blood pressure (<140/90)
4. Childhood immunization status - combo 10

They also offer supplemental training in change management (practice skills to support effective change), Lean six sigma, motivational interviewing, social determinants of health (SDoH), and trauma – informed care. Additionally, The Association offers data analytics and support for health centers through the development of consistent metrics for quality initiatives allowing the health centers to better track progress. With The Association’s support, health centers have learned about data validation practices and what to look for in choosing health information technology tools. Staff at The Association recognize the value of using data to drive performance improvement as demonstrated by the use of quarterly data submissions by their quality improvement work group. Similarly, through the utilization of health information technology tools and support from the Association, member health centers are able to take a data-driven approach to transformation by tracking, improving, and managing health outcomes and costs. This data-driven approach has demonstrated impact as seen by improvement on key measures by many of the health centers from 2016 to 2018. The Association also utilizes data to drive health center innovation. A recent project described literature on SDoH and diabetes, screening tool uses and pilots and magnitude of risk for diabetes with the hopes of future health center participation in research which could impacts patients at the health center, state, and even national level.

Care Delivery

The “Care Delivery” domain of NACHC’s Value Transformation Framework features five change areas: population health management, patient-centered medical home, evidence-based care, care coordination and care management, and social determinants of health. The Association relies on practice transformation as the basis for the memberships’ ability to expand access to care and additional services. The Association provides support for population health management through peer learning opportunities and the supplemental quality trainings.
such as their work around change management. The Association also offers resources for member health centers seeking Patient-Centered Medical Home (PCMH) status from the National Committee for Quality Assurance (NCQA). Specific to those members seeking PCMH status, The Association provides project management assistance, document review and feedback, NCQA resources and timelines (such as a regularly updated frequently asked question document), and a peer-link with other health centers who have or will be going through the recognition or renewal process. The support provided by The Association is tailored to each health center and recognizes PCMH is just one of the ways in which health centers are approaching care delivery.

Other ways in which health centers are approaching care delivery which The Association supports is through an emphasis on evidence-based care and care coordination and care management. For example, in 2018 and 2019, The Association presented trainings on topics ranging from the Health Network Program to blood pressure measurement and management. They also presented a webinar series on “Putting PCMH into Practice” which explored not only the process for recognition but also how health centers could implement team-based care, manage their patient population, patient-centered access, care transitions, and performance measurement among other topics. In 2018, The Association designed a Social Determinants of Health screening implementation tool kit and provided data analysis for health centers participating in a national pilot program (PRAPARE). Trainings and resources like the ones highlighted exemplify how The Association seeks to support health centers as each one builds healthcare access, innovation, and value through transforming care delivery.

People

The “People” domain of NACHC’s Value Transformation Framework features five change areas: patients, care teams, leadership, workforce, and partnerships. In each of these five change areas, The Association supports health centers take actionable steps. As demonstrated by the reach of their member health centers, their mission, and their actions, patients are at the heart of all of The Association’s work. As many of the staff at The Association are patients at member health centers, they utilize their lived experience to incorporate the patient perspective into their work and, as a result, design processes meant to improve the patient experience. The Association also encourage team-based, coordinated care among doctors, mid-level practitioners, pharmacists, and patient navigators and advocates for policies to support health centers’ ability to provide such care. Through training and technical assistance, The Association is leading the way for health centers to provide quality, comprehensive care which is an essential part of the quadruple aim. Leadership is supportive and encouraging and utilizes the feedback from their members to drive their work and priorities. They also analyze Uniform Data System (UDS) metrics to inform training and technical assistance and are responsive to changing environmental factors. For instance, as health centers were facing transformation challenges, the Association began offering change management training in collaboration with Integrated Work Strategies called the “4D Approach to Change Management”. At the change management training, attendees came with a specific change idea (for example a workflow or process change) they were trying to implement in their health centers. During the in-person training, attendees developed an action plan which demonstrated their ability to put into practice the theories being taught at the training.

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Number of Health Centers in Washington with PCMH Accreditation in 2018
Workforce is another key area in which The Association supports their members. Not only does the Association assist with recruiting and retaining highly-skilled health professionals, it conducts workforce development events to help health center staff gain skills necessary to address a changing population and shifting needs. When The Association saw the rate of turnover for medical assistants in health centers, they developed a program (In-REACH Apprenticeship Program) to support on-the-job training and certification of Medical Assistants. This program has led to an increase in retention rates, especially as compared to the national average (the two-year retention rate is above the 80th percentile). The In-REACH program also has a unique partnership with local community colleges to allow participants to earn college credits at the same time. The Association assists in addressing changing workforce needs including team structure, hiring, and additional training. Finally, The Association wants to enable expansion of the primary care team through partnerships. As an association, it brings their members together to partner, collaborate, and advance health care access and outcomes. In the Association’s words, “by working together, community health centers exchange ideas, identify shared concerns, and develop solutions that benefit patients.” Partnerships are key to the successful outcomes envisioned for health centers in Washington State and the patients.

Conclusion

Through policy advocacy and implementation, convening, and capacity building, health centers in Washington are supported by The Association in the pursuit of the Quadruple Aim. As exemplified by The Association’s work in the domains of infrastructure, care delivery, and people, health centers are able to focus on improving the patient experience, health outcomes, cost of care, and care team well-being. This enables the health centers to better serve over 1 million patients. The work of The Association and their 27 member health centers is a model for strategic goals and actionable steps to advance quality care for all.
This document was produced by the National Association of Community Health Centers.

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This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement number U30CS16089, Technical Assistance to Community and Migrant Health Centers and Homeless for $6,375,000.00 with 0% of the total NCA project financed with non-federal sources. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.