For more than 100 years, the Cooperative Extension System (CES) has led the way in innovation discovery in American agriculture and farming. It is heralded as one of the most successful technology catalyst programs of all time, ensuring food production at critical times in our recent history. Thanks to its connection to land-grant universities, there are now CES agents in nearly every U.S. county who continue a legacy in rural and farming communities, but who are also enabling a new generation of farmers and the locally-sourced food movement that supplies many of your favorite restaurants. The CES also has a National Framework for Health and Wellness that aims to help create healthy and safe communities, support clinical and community preventative services, and contribute to the elimination of health disparities. The well-tested and well-developed CES recognized an important opportunity to help improve health beyond food production.

More than a decade ago, Dr. Don Berwick and others recognized the potential for the Cooperative Extension model to be a boon for discovering healthcare innovations and speeding up the testing and dissemination of those innovations across physician practices. Family medicine innovators, like Dr. Art Kaufman in New Mexico, and Dr. Jim Mold in Oklahoma, built co-op-like models of practice support and change-facilitation that have operated successfully for nearly two decades. In 2009, the Health Information Technology for Economic and Clinical Health (HITECH) Act was launched as a component of the American Recovery and Reinvestment Act. This act created 62 Regional Extension Centers that worked with individual practices to speed up adoption of electronic health records (EHRs). Congressional staffers who drafted the HITECH Act borrowed the extension model for EHR adoption. That toe-hold for healthcare extension became the nidus for the Primary Care Extension Program (PCEP) authorization in 2010, which was written, in part, by a small group of family medicine leaders.

In 2011, the Agency for Healthcare Research and Quality piloted the PCEP concept with Infrastructure for Maintaining Primary Care Transformation (IMPaCT), and then in 2015 launched the much larger EvidenceNOW, which is providing quality improvement services to 250 small- and medium-sized primary care practices across 12 states. IMPaCT influenced the Centers for Medicare and Medicaid Services to launch two related demonstrations in 2015: The Comprehensive Primary Care Initiative (now in its second generation as CPC+) and the Transforming Clinical Practice Initiative (TCPi).

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TCPi aims to reach 140,000 clinicians across all states, providing practice assessment, transformation, and improvement services through 29 Practice Transformation Networks. CPC+ provides multi-payer payment reform and transformation support to nearly 3,000 practices in 18 regions. These three projects will put nearly $1 billion into testing the value of local practice transformation services.

The ABFM believes that extension-like services are important to helping family medicine practices survive and thrive. For that reason, we are directly participating in TCPi with the ABFM PRIME Support and Alignment Network and supporting both EvidenceNOW and CPC+. It is also one of the reasons the ABFM created the PRIME Registry and is offering three years of free registry enrollment for thousands of family physicians.
The Transforming Clinical Practice Initiative (TCPi) is fortunate to have the TCPi National Faculty, a dedicated group of experts ready and able to support Practice Transformation Network (PTN) participants in achieving the TCPi aims. Faculty members support the TCPi community by sharing their own expertise and experience.

We are happy to report that family medicine is well-represented among the National Faculty, and many active and alumni faculty are ABFM Diplomates. Here is some transformation wisdom from six of our champions, Drs. Meisinger, Funk, Reeves, Chouinard, Grant-Nierman, and Elmer.

**Kirsten Meisinger, MD, National Learning Facilitator**

“Transformation is really just starting to do things the way you have always wanted them done! Only do not do them alone. The first thing is to form a solid leadership team with a shared vision of where you all want to wind up. This is the basis for all the team-based work that follows. With that team on board, you can accomplish anything!”

I am the Medical Staff President for the Cambridge Health Alliance (CHA), a safety net ACO, located north of Boston, Massachusetts. I also work as a Family Medicine physician at Union Square, a full-spectrum Family Medicine primary care site with approximately 8,000 patients. The patient population includes a large mix of Brazilian, Spanish-speaking, Nepali, Indian, Haitian-Creole and other immigrant groups; many of these patients are uninsured. Our highly effective teams have been able to achieve and maintain quality goals for cancer screenings, diabetes and depression treatment for over five years. We have also quickly surpassed all of our immunization and new mental health screening goals in the past year. We have found that high functioning teams are the cornerstone of the exceptional quality attained and maintained by Union Square. Multi-lingual, highly trained and effective staff maximize every opportunity to achieve quality care through both in-reach and outreach. We know how to deliver high quality care to the most vulnerable population in the country! Talk to us.

**Karen Funk, MD, MPP, National Learning Facilitator**

“Failure is fertile ground for team-based primary care transformation.”

I am the Vice-President of Clinical Services at Clinica Family Health, a federally qualified health center, in Lafayette, Colorado. We have approximately 47,000 patients with 97% of our patient population living at or below 200% of the poverty line. Clinica Family Health was the first community health center in the state of Colorado to achieve National Committee for Quality Assurance Level 3 patient-centered medical home status in 2010. Our robust, integrated team-based environment sustains quality outcomes for our vulnerable patient population over time. For the 13 quality outcomes that we track for which there are Healthy People 2020 goals, Clinica Family Health has met or surpassed goal for 8 of them. We have maintained a 2% readmission rate for our population through our inpatient service with partner hospital Avista and our home-visit based transitions of care program. Our organization values continuous improvement of actionable business intelligence tools that continue to push the boundaries of what is possible with population management for all roles on the care team. We have been able to clearly define roles on the care team so that everyone can see and value what they have to offer in the care of the patient; this helped to transform how we worked as a team to deliver quality health outcomes. In order to transform you must be brave and trust that the group is wiser than the individual.

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Family Medicine Experts Champion Practice Transformation

Mary Reeves, MD, National Learning Facilitator

“Be bold. Fail forward. You can do this!”

I am a Family Medicine physician. I spent my 22 clinical practice years at First Street Family Health (FSFH), a 4-doctor independent practice serving a rural population in the central Colorado mountains. Salida, Colorado is a small town (pop. 5,300) that has a critical access hospital; the only hospital for 1 hour in any direction and is 2-3 hours from tertiary care. FSFH started its transformation journey as part of the Comprehensive Primary Care Initiative (CPCI) in 2011. By coordinating patient care, we were able to reduce emergency room visits by 22% in 1.5 years despite overall growth in our practice. Implementing Team Based care strategies opened access, improved office efficiency and morale and increased revenue. Transformation has required a major culture change for our practice. We are an old practice, and fears about what transformation would mean for our long-serving employees was a major challenge. We were intentional about not wanting to lose employees during the transformation and used financial incentives for education and time to change workflows. All take pride now in our progress. I retired from clinical practice in 2015, but the journey continues as FSFH is a CPC+ practice that is navigating track 2 payments under the Quality Payment Program. I recommend that practices start their transformation journeys with empanelment and risk assessment, using that data to identify strengths, priorities and improvement opportunities. I also recommend starting a Patient and Family Advisory Council early on – it will bring a supportive patient voice to your transformation efforts. TCPI brings technical support to practices for this transition that benefits patients, clinicians and staff and positions the practice to benefit from new payment models. It is my honor to serve as faculty and share my experience and excitement with practice transformation.

Sarah Chouinard, MD, National Co-Chair

“By using technology tools to capture population level health data, we can plan for and maximize each office visit so that patient has a better experience and better health outcomes. Teams are key to ensuring that all of the work gets done so that no one experiences burnout or misses key metrics.”

I am the Chief Medical Officer of Community Care of West Virginia (CCWV), a federally qualified health center with multiple locations throughout nine counties in central West Virginia. CCWV includes primary care offices and school-based health centers with approximately 37,000 patients. The patient population consists of a rural Appalachian group of isolated communities with very few other healthcare options in our service areas. We have been using data to drive improvement over the last five years. In 2016, we were better than the West Virginia state average in 9 out of 13 clinical measures. The most powerful function we have in our office is technology tools that allow us to track both performance measures and outcome measures. We provide routine feedback to all members of the care team about performance with close follow up to ensure that goals are being met and improvements are being made via “Plan, Do, Study, Act.” Our culture is truly continuous quality improvement. We use routine webinars, face-to-face meetings, and close control over data to ensure progress across our large geographic spread. “That’s the way we’ve always done it” is now forbidden language at CCWV. Everyone must be open to change. Change means progress.
“Start with a gut check: What transformation project invigorates your desire to come to work? Grow from there.”

I am a partner and family medicine physician at the privately owned First Street Family Health in Salida, Colorado, which has approximately 8,000 patients. We serve a rural community and tend to patients from up to two hours away in the surrounding rural communities of the south-central Rockies. I have worked hard for two years to develop a plan for transitioning into team-based care for our office. We have also developed a Patient and Family Advisory Council that has provided robust patient feedback for enhancing that patient experience. Our practice has found that transformation works when physicians and leadership who are forward-thinking and unafraid of change are aligned with a common goal. We celebrate successes with everyone and point out to them how they are the ones who made the practice succeed. As we develop a culture of improvement, we empower staff at all levels to come up with problems to tackle and to engage in the process of improvement. The transformation journey starts with physicians and nurse leadership and needs to identify priorities, those individual intrinsic motivators and emotional drivers that bring us to work every day.

“Either I am the greatest doctor in the world, or I am a good doctor surrounded by great processes.”

I have been the Chairperson of Thedacare Primary Care Compensation committee for the past 22 years. Thedacare is a non-profit, multi-specialty delivery system located in Appleton, Wisconsin consisting of seven hospitals and 34 primary care clinics that serve with approximately 240,000 patients and includes both rural and suburban areas. For the last five years Thedacare has led the Wisconsin Collaborative for Healthcare Quality (WCHQ) metrics for disease management/preventive care metrics. We have also been the value leader for the Pioneer ACO project. We have had exceptional success in utilizing lean process improvement in healthcare. We redesigned our workflows, goals, and mission to truly focus on patient needs and desires. Lean process improvement is a “tool box” that operates within the organizational culture you create. In order to transform, we had to first understand and accept that healthcare in the United States is going through a profound change. The shift from volume to value is upon us.
TCPi in San Antonio at FMX 2017

The PRIME Support and Alignment Network (SAN) team and its federal Program Officer, Commander Rebecca Bunnell, P.A., Senior Advisor, Learning and Diffusion Group, Center for Medicare & Medicaid Innovation, enjoyed meeting family physicians at the 2017 Family Medicine Experience (FMX), the AAFP’s annual meeting. The PRIME SAN team talked with family physicians about practice transformation and demonstrated the ABFM’s PRIME Registry dashboard and quality improvement tool designed to help practices succeed in the transition to value-based payment systems like Medicare’s Quality Payment Program.

The ABFM certification department team was in the adjoining booth answering physicians’ questions on continuous certification. The ABFM PRIME SAN and the PRIME Registry are part of the ABFM’s mission to continuously add value to family medicine board certification.

Watch for the PRIME SAN and PRIME Registry teams at FMX 2018, Oct 9—13, in New Orleans, Louisiana

Dr. Bob Phillips, PRIME SAN Director, and Dr. Elizabeth Bishop, PRIME SAN Manager, with Ms. Ashley Webb, ABFM Support Center Manager, at the keyboard
TCPi CME Sessions at FMX 2017

There were three TCPi-sponsored sessions at FMX 2017:

Setting up a Patient Family Advisory Council in Your Practice
Faculty: Dr. Mary Reeves and Ms. Desiree Collins Bradley

Practice Transformation 101: The Mindset and Techniques
Faculty: Dr. Ryan Mullins

Tools for Improving Access and Continuity
Faculty: Dr. Jean Antonucci

After the Patient and Family Advisory Council session, Dr. Dan Bloch was “energized” and wants his practice to begin “doing something a little beyond the standard.” He plans to encourage his colleagues and practice to “step out of the pack” and incorporate more family engagement opportunities. We plan to follow up with Dr. Bloch and hear more about his transformation story later this year.

TCPi Member Interest Group at FMX 2017

We caught up with the TCPi team (barely!) on its way to the TCPi Member Interest Group (MIG) meeting. The MIG meetings were recently implemented at FMX. The TCPi MIG was among the first round of MIGs established.

This year at FMX, the MIG organized a panel to kick off the discussion of best practices for transformation. The panel included Dr. Bob Phillips, ABFM Vice President of Research and Policy and family physician in Fairfax, Virginia; Dr. Elizabeth Bishop, ABFM PRIME SAN Program Manager; current TCPi National Faculty members: Dr. Mary Reeves, retired family physician in Salida, Colorado, Ms. Desiree Collins Bradley, and Commander Rebecca Bunnell, P.A., Senior Advisor, Learning and Diffusion Group, Center for Medicare & Medicaid Innovation. Attendees at this year’s in-person MIG meeting were engaged, and the panel discussion offered valuable information and support. Beyond the TCPi project, AAFP staff are working with Dr. Reeves as the member-leader of the MIG to increase engagement and help sustain the TCPi MIG community.
ABFM’s PRIME Registry in Action

Real Users, Honest Feedback

In July of 2017, the ABFM’s PRIME Registry team visited Dr. Jim Kennedy (now retired), and his daughter, second generation family physician Dr. Kelley Glancey, in their small, rural family medicine practice in Colorado. Below are excerpts from the conversation, highlighting ways their practice is using the PRIME Registry to meet the challenges of multiple reporting requirements. You can view the video of our conversation with Drs. Kennedy and Glancey at primeregistry.org.

Dr. Kennedy: “All these new requirements, which PRIME is here to help us with, have created a tremendous difficulty for primary care physicians. The burnout rate is astronomical. In rural America…it’s almost hard to keep your doors open.”

Dr. Glancey: “I chose family medicine because I just always knew from seeing my dad when I was growing up that it was the right field for me… I wanted to be able to spend time with people, getting to know them really well, knowing their story… In this day and age of even family medicine, for some people, that piece is really disappearing because people are spending a lot of time doing lots of other things that don’t involve actually taking care of their patients.”

“We decided to enroll in the PRIME Registry because we needed the reporting capabilities for CPC and CPC+ as well as the SIM initiative. We also kind of decided to enroll in the PRIME Registry because of the free offer that we got from the ABFM.”

“We did a lot of back and forth work with FIGmd (ABFM’s technology partner) trying to make sure that all of our data was accurate, and that they were collecting things in a way that worked for us….Even though it takes some time, in the end, it was worth it, because our registry is designed to be personal to us, which is different than what you get from just your straight EMR CQM reporting.”

Dr. Kennedy: “…They can pull the data out of any piece of the chart anywhere we want them to pull it from and instead of having to put a piece of data in one particular area, they’ll find it, as long as you tell them where they can find it, and they’ll report it. It’s taken us two or three iterations of them pulling data and saying, ‘does this work?’”

Dr. Glancey: “Within the dashboard…you’re able to create your own section of favorites so you can make a list that just shows you the CQM pieces that you’re working on because the list of things they can report on is very long. So, I just go through and look at the ones that I need to report for both CPC+ and SIM, and I can have those all on one page and sort of look at those and make sure that we’re meeting the benchmarks that we need to meet.”
The Added Value of PRIME Modules

- Merit-based Incentive Payment System (MIPS) eligible Medicare providers automatically report your CQMs and attest to your Improvement Activities and Advancing Care Information
- EvidenceNOW practices automatically report your CQMs to AHRQ
- Comprehensive Primary Care Plus practices meet quarterly self-reporting requirements and automated annual reporting

Launching later this year, the Population Health Assessment Engine (PHATE™) will integrate with PRIME to allow you to analyze the impact of social determinants on individual patients and populations.

Log in to primeregistry.org to view our PRIME Registry demo calendar for upcoming webinars and to see the latest updates.

PRIME is free for ABFM Diplomates for the first three years. That's a savings of $885!
Visit primeregistry.org/how-to-register for more information.

Use the PRIME Platform for Your Performance Improvement Activity Credit

Whether or not you're enrolled in The PRIME Registry™ you can access an improved ABFM Performance Improvement (PI) activity credit platform.

If you are enrolled in PRIME, the PI activity module is accessible from your PRIME dashboard, as seen below. Once there, select the CQMs you want to target for improvement and activity credit. If you’re enrolled in The PRIME Registry™ you won't need to enter your data manually; it will automatically appear from your PRIME CQM account.

Otherwise, if you are not enrolled in PRIME, the PI activity module is accessible from your Physician Portfolio.
New Measures, Better Reimbursement for Care that Matters

PRIME Registry™ is a Qualified Clinical Data Registry, a status that enables the ABFM to develop better measures of care, which can lead to better Medicare reimbursements. Highlights for 2018 include implementing the newly developed “Provider Level Continuity Measure,” which was recently approved by Medicare for the MIPS 2018 performance year.

This Provider Level Continuity Measure is derived from the Bice-Boxerman Continuity of Care Primary Care Physician Measure. It is a structural measure that considers the dispersion of primary care visits across providers such that patients with higher scores have most of their primary care visits with the same provider or a small number of providers, while those with lower scores see a larger number of providers. The patient level scores are then used to calculate a physician level measure.

For more information see “Continuity of Primary Care and Emergency Hospital Admissions Among Older Patients in England” in the November/December 2017 volume of the *Annals of Family Medicine*, accessible at annfammed.org/content/15/6/515.full.

Wait a Minute! Who’s Got My Data?

All registry data is maintained in compliance with HIPAA, subject to a Business Associates Agreement, but the ABFM has gone a couple steps further to protect your data. Our data team at FIGmd has no rights to use identified data without your permission, and the ABFM cannot touch your patient data except for research purposes and only after Institutional Review Board approval.
Practice Transformation Network and Performance Improvement Activity Update

As of September 2017, there were 7,831 family physicians enrolled in Practice Transformation Networks (PTNs) across the U.S. as part of the landmark federal Transforming Clinical Practice Initiative. These physicians and their practice teams are actively receiving practice facilitation and technical assistance to succeed in the transition to Medicare’s Quality Payment Program.

Just over 400 board-certified family physicians attested to their PTN-facilitated Quality Improvement activities and received ABFM Performance Improvement activity credit for that work.

Those physicians shared with us reasons they joined a PTN and how it worked for them. One family physician from a small, independently-owned medical practice shared that they joined a PTN because they “found an extreme lack of support or even community with[in] our healthcare system locally. We needed more support as we strive to innovate and bring new models of care to primary care.”

Another physician from a medium-sized (6-20 providers) health system-owned practice shared that the assessment tool “helps to redesign primary care to become more efficient.” Another said they learned from the assessment to “adjust some of our pre-visit planning and prevention screening practices to accommodate those patients that do not require or wish to have recommended preventive services.” Other diplomates reported that the PTN facilitators “assisted with gathering workflow tools and offered CME training and Best Practice blogs and networking to other PTNs for resources [and also] … identified major quality metrics, and established baseline performance and set targets.”
Transformation Tools You Can Use, Courtesy of our TCPi Partner Organizations

Note: you do not need to be enrolled in TCPi to access these practice improvement tools and resources.

University of Colorado e-Learning modules to support practice transformation

The ABFM PRIME Support and Alignment Network, in collaboration with the University of Colorado School of Medicine, Department of Family Medicine, is proud to announce the availability of three new Performance Improvement (PI) activity e-Learning modules to support practice transformation.

Physicians have a choice of completing one of the following three modules to receive 20 ABFM Performance Improvement activity credits. All three modules integrate the key TCPi drivers and the concepts of Bodenheimer’s 10 building blocks of high-performing primary care.

Module 1: Person- and Family-Centered Care Design

Patient engagement has been broadly recommended as a way of improving patient-centeredness and overall value. In this module, learn how to apply key concepts for engaging patients and families to improve your practice’s care.

Module 2: Care Coordination Across the Medical Neighborhood

The “medical neighborhood” provides a framework for structured, reciprocal relationships that integrate specialty care and extend the principles of the medical home to all physicians. Use this module to learn and apply concepts of coordinating patient care across the medical neighborhood.

Module 3: Cost and Value of Care

The U.S. has the highest costs related to health care, and in this module you will learn the main concepts of improving the cost and value of care and develop a plan for your practice.

How to access the modules: portfolio.theabfm.org/mcfp/ppm.aspx

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American College of Emergency Physicians Support and Alignment Network

The American College of Emergency Physicians’ (ACEP) Emergency Quality Network (E-QUAL) is designed to engage emergency clinicians and leverage emergency departments (EDs) to improve clinical outcomes and coordination of care. It also reduces costs in the following areas:

- Improving outcomes for patients with sepsis
- Reducing avoidable imaging in low-risk patients by implementing ACEP’s Choosing Wisely recommendations
- Improving the value of ED evaluation for low risk chest pain by reducing avoidable testing and admissions.

Each of the learning collaboratives has a 9-month learning period where participating sites will complete quality improvement activities (including submitting benchmark data) through the E-QUAL portal. In addition to the quality improvement activities, E-QUAL will host monthly webinars and podcasts, and sites will have access to toolkit resources and best practice guidelines.

For more information visit https://www.acep.org/equal/

American College of Physicians Support and Alignment Network

The American College of Physicians (ACP) Support and Alignment Network is proud to offer a number of tools and resources to all physicians at low or no cost, regardless of PTN status, to help them transform their practice.

ACP Practice Advisor® is our premier online practice improvement tool with 40+ modules, many of which offer CME/MOC (multiple specialties) credit for completion. PTN-enrolled clinicians and teaching practices can access all modules in the tool for free. Others can use it for a fee. There are also several free access modules, including our newest on addressing clinician burnout.

ACP’s online, interactive High Value Care cases and Pediatric High Value Care Cases on a variety of topics help physicians learn how to eliminate unnecessary healthcare costs and improve patient outcomes and are also FREE and confer CME and MOC points. These cases mirror Choosing Wisely concepts.

Free opioid management tools include the SAFE Opioid Prescribing course (3.5 CME and MOC). Other free resources can be found at ACP’s Online Learning Center.
Transformation Tools You Can Use, Courtesy of our TCPi Partner Organizations

American Medical Association (AMA) Support and Alignment Network

STEPS Forward includes the American Medical Association’s (AMA’s) Practice Improvement Strategies and Medicare Access and CHIP Reauthorization Act of 2015 Quality Payment Program (MACRA/QPP) resources. It is a free, online platform offering education, process improvement initiatives, metrics, and tools with the goal of enhancing practice transformation. The AMA’s STEPS Forward practice improvement educational modules help physicians prevent burnout and address common practice challenges to achieve happier and healthier patients and lower costs.

What does it offer?

- 50 modules of content
- Free CMEs
- Real-life case studies
- Downloadable tools
- The AMA’s MACRA/QPP resource, Navigating the Payment Process, includes tools and resources for physicians such as the MIPS Action plan and Payment Model Evaluator

For more information, visit stepsforward.org and d8.ama-assn.org/topic/navigating-payment-process

HealthCare Dynamics International (HCDI) Support and Alignment Network is committed to supporting practices to continue to provide the highest quality of care. HCDI is delighted to share the ‘Caring for Your Health’ (CFYH) Social Determinants Indicator Tool. The CFYH Social Determinants Indicator tool was created in response to clinicians’ concerns regarding the social factors affecting their patient populations, the impact of these factors on clinical outcomes, and the subsequent negative adjustment that can result under MIPS. These social factors may also affect the patient’s ability to self-manage and adhere to their shared decisions. This brief questionnaire is patient facing and provides real-time, up-to-date information to the provider, while creating an opportunity for shared decision-making with the patient. The tool and all support are free of charge.

The CFYH Social Determinants Indicator tool is both a patient level and population health management tool that:

- provides real-time opportunities for clinicians to address socioeconomic factors that can affect the patient’s clinical outcomes
- supports patient risk stratification
- enables the documentation of the patient case complexity
- promotes early intervention
- supports the Improvement Activity (IA) Performance Category under MIPS

Visit tcpisan.org/?page_id=715 to see the CFYH tool.

Another important resource from HCDI is the Physician Behavior Survey on Type 2 Diabetes Management, part of a larger effort to gather meaningful data from a wide range of clinicians that will inform and streamline bests practices around type 2 diabetes management. In an effort to maximize the scope and spread of the HCDI TCPI-SAN Physician Behavior Survey on type 2 diabetes management, it has become necessary for HCDI to take an “All Hands On Deck” approach to getting this survey completed, and the data gathered.

Please help out by filling out the survey at surveymonkey.com/r/PCD7WZD
Network for Regional Healthcare Improvement Support and Alignment Network

The Network for Regional Healthcare Improvement (NRHI) Support and Alignment Network offers learning programs in high-value care areas including: Measuring and Understanding Total Cost of Care, Behavioral Health Integration, Reducing Unnecessary Utilization, Navigating Payment Reform, Designing and Evaluating Quality Improvement Programs, Advancing Care Management, and Improving Person and Family Engagement. In 2018, the NRHI SAN is launching learning programs focused on strategies to address imaging for low back pain and cost of care and strategies to improve access to address emergency department utilization. Our programs are delivered live via webinar and archived in our online community with key take-aways and accompanying tools and resources. The webinar content is appropriate for Quality Improvement Advisors, practice staff, and clinicians.

For more information, visit nrhisan.healthdoers.org/home or contact Stacy Donohue at sdonohue@nrhi.org or by phone at 207-805-1678.

American Psychiatric Association Support and Alignment Network

The American Psychiatric Association (APA), in collaboration with the AIMS Center at the University of Washington, has developed trainings for both psychiatrists and primary care physicians. These trainings are offered live and online. The APA also has an array of resources, including webinars on the model for primary care physicians, information on reimbursement in collaborative care, and a financial modeling workbook.

These online trainings and resources can be found on the APA website at www.psychiatry.org/san

Patient-Centered Primary Care Collaborative Support and Alignment Network

The Patient-Centered Primary Care Collaborative (PCPCC) offers the following customized training, resources, and technical assistance to support the improvement of Patient and Family Engagement (PFE) programs:

- Coaching calls with PFE subject matter experts
- Virtual trainings and webinars customized to meet Practice Transformation Network (PTN) and clinicians’ specific needs
- On-site workshops or technical assistance
- Assistance with developing community partnerships with local YMCAs that align with TCPi aims
- Support for patient and family advisors through the IPFCC’s PFCC
- Connect, an online portal for patients and family members, clinicians, health care staff, and administrative leaders.

For more information, visit pcpcc.org/tcpi
SUPPORTING TRANSFORMING

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