PATIENT-CENTERED PRIMARY CARE HOME IMPLEMENTATION TASK FORCE REPORT

Oregon Health Authority and Northwest Health Foundation

Office for Oregon Health Policy and Research
Patient-Centered Primary Care Home Program

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Oregon Health Authority

NORTHWEST HEALTH FOUNDATION

The Community's Partner for Better Health

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Background

The Patient Centered Primary Care Home (PCPCH) is part of Oregon's efforts to fulfill a vision for better health, better care, and lower costs for all Oregonians. Primary care homes achieve these goals by coordinating the needs of patients through a single team of health professionals, providing comprehensive and continuous care for patients and their families, keeping them healthy, out of the hospital, and living their lives. In its 2010 Action Plan for Health, the Oregon Health Policy Board charged the Oregon Health Authority (OHA) with providing access to patient-centered primary care beginning in 2011 for all of its covered lives including Medicaid members, state employees, and Oregon educators. The ultimate goal is that 75% of all Oregonians will have access to care in a Patient-Centered Primary Care Home by 2015.

As part of its work toward meeting this goal, OHA partnered with the Northwest Health Foundation (NWHF) to convene a diverse group of task force members from across Oregon including clinicians, patients, public health, and healthcare delivery technical experts to provide recommendations that would support broad implementation of the primary care home model across Oregon. The task force membership is listed in Appendix A.

In order to tackle this complex analysis, four task force workgroups were developed based on the feedback from targeted interviews conducted by OHA in June 2011 as well as a survey conducted by NWHF in June 2010. The workgroup topic areas were: I. Quality Improvement and Change Management, II. Leadership Development and Patient Engagement, III. Clinic and Virtual Care Teams, and IV. Data Support. Additional technical experts were invited to participate on each workgroup (included in Appendix A).

Please note that throughout the report, Patient-Centered Primary Care Homes are referred to as primary care homes and PCPCH for the purpose of brevity.

Priority Task Force Recommendations

The task force produced 16 general recommendations with over 70 specific strategies for achieving them, prioritizing them based on what is most essential in terms of timing and impact for primary care home implementation across Oregon over the next few years. Below are the recommendations that were evaluated as overall top priorities by the task force. Beginning on page three, the priority recommendations from each workgroup are discussed, and see Appendix B for a complete list of recommendations and strategies.

Top Priority Recommendations for Successful Implementation of Primary Care Homes

- **Create a Patient-Centered Primary Care Home Institute and technical assistance strategy -** The task force emphasized the tremendous need to build clinics' capacity to transform in order to make implementation of primary care homes possible. The top priority identified by the task force was to build on the expertise, technical assistance, and best practices already taking place throughout Oregon

by creating a PCPCH Institute to convene resources, provide technical assistance, and create a centralized learning system. The PCPCH Institute would create a structured collaboration to:

- Identify clinic readiness for transformation and adoption of primary care homes
- Assemble a package of technical assistance tools and resources for broad dissemination
- Create a learning network that builds on best practices by continually integrating new learning into on-the-ground change efforts
- Develop "Transformation Teams" made up of patient advisors, QI professionals, and clinicians experienced in patient-centered primary care to act as technical advisors
- Implement a train-the-trainer approach to widely disperse knowledge to various geographic areas

The Oregon Health Authority, in partnership with the Northwest Health Foundation, immediately advanced this recommendation from the task force and submitted a proposal to members of the NWHF's board to request initial funds for the PCPCH Institute. The Northwest Health Foundation board approved this request, which will be almost fully matched by OHA, resulting in approximately $300,000 to create a PCPCH Institute. The planning and details around the PCPCH Institute are currently underway. In addition, we will be looking for funds to support this effort beyond the initial infusion of NWHF and OHA dollars, and hope to sustain the effort as long as the need exists for technical expertise in practice transformation to improve health care in Oregon.

- ❖ Build a common framework for *patient-centeredness* - Engage with key leadership in the state to explore ways to integrate the involvement of patients and families into implementation of primary care homes. Explore interest in sponsorship to bring an intensive targeted seminar to Oregon through the Institute for Patient and Family Centered Care.
- ❖ Increase the capacity of behavioral health professionals to provide services in primary care homes – To address the workforce shortage, provide training opportunities for existing behavioral health professionals to develop competency in a brief therapy intervention model geared to primary care settings.
- ❖ Remove barriers and align Coordinated Care Organizations (CCOs) with Patient-Centered Primary Care Homes - Remove the legal/regulatory barriers that may affect adoption of primary care home standards and align the requirements of CCOs to support and incentivize adoption of primary care homes.
- ❖ Implement a strategic PCPCH communications and outreach plan – Engaging stakeholders through strategic communication and outreach is essential for increasing awareness, building the will to change, and creating shared success and learnings.
- ❖ Convene a statewide group of healthcare stakeholders to reach consensus on how to provide primary care providers with real-time actionable data on patients who inappropriately use the ED or are admitted to the hospital for ambulatory sensitive conditions.
- ❖ Provide assistance to all clinics in developing data competency skills and embedding population registries.
- ❖ Provide a standard patient satisfaction tool and mechanism for collecting clinic data.
- ❖ Broadly disseminate screening and assessment tools and train primary care providers and staff how to implement in clinics (e.g. SBIRT for substance abuse).

The Patient-Centered Primary Care Home Program within the OHA has already begun creating a workplan to address the recommendations from the task force. The initial primary focus will be on fleshing out the details and drafting the RFP to create the PCPCH Institute and technical assistance strategy. Concurrently, the PCPCH Program is developing a strategic communications plan to begin the important work of outreach and engagement with stakeholders and the primary care community. Please visit the PCPCH Program website for updates on this work at www.primarycarehome.oregon.gov

Recommendations by Work Group

I. Quality Improvement and Change Management Workgroup

Implementation of primary care homes is a complex transformation of an organization that requires knowledge of quality improvement principles and tools as well as change management experience, which may not exist within practices. Based on experience from organizations within our state as well as national learnings, the capacity of clinics to change is highly variable. Even organizations with established quality improvement infrastructures discover that transformation is difficult. In order for widespread adoption of PCPCHs to occur, clinics throughout Oregon will need support and technical assistance for all staff and providers within an organization.

Effective Components of PCPCH Transformation

- Building Will for Change - Creating a compelling reason and a business case - Why Should I Do This?
- Basic Quality Improvement Training - Webinars, collaborative, and on-site training
- Clinic Coaches - Builds experience in the basic quality improvement methodology (Plan-Do-Study-Act) and provides ongoing support
- Continuous Feedback to Providers via Data Collection Support – Using data to understand if a practice change made a difference in what they were trying to improve
- Leadership Development - Throughout the organization at many different levels

There are bandwidth considerations for each clinic as they consider PCPCH implementation. For instance, a clinic in the throes of EHR implementation can be overwhelmed and resistant to making other practice changes. The Meaningful Use incentive available to providers has been a real barrier to participation in PCPCH projects in the last year. However, it can be a prime time to integrate the PCPCH standards (e.g. selecting an EHR that can support PCPCH transformation, standard reports that will capture PCPCH indicators). Understanding how best to strike a sustainable balance is an important consideration as full-scale implementation occurs across Oregon in the next 18 months.

Additionally, the delayed payment alignment continues to be a barrier and key contributor to disengagement of physician leaders. Addressing this issue will go a long way in building will and helping reduce the reluctance of practices to adopt the PCPH Standards. OHA, payors, and plans should work together to address payment reform strategies that advance the sustained transformation of primary care in Oregon.

Priority Recommendations from the Quality Improvement and Change Management Workgroup

A. Establish a PCPCH Institute and technical assistance (TA) strategy to accomplish the top priorities identified by this workgroup:

- A.1. Leverage the expertise and success already taking place in Oregon. Our state is well-connected with national collaboratives and there is extensive quality improvement (QI) expertise across a number of organizations. However, there is no coordinating mechanism among the various efforts and no venue where organizations can share learning and build upon their collective wisdom.
- A.2. Understand the current environment by assessing clinic readiness. It will then be possible to create a strategic plan with effective interventions to move clinics along the continuum of transformation. Target the development of QI knowledge in areas where gaps exist and where access to resources is limited.
- A.3. Collect and disseminate a package of TA resources available broadly to clinics and others. This would be accomplished by convening a collaborative of QI experts/organizations in Oregon to identify standard best practices and leverage resources to continually integrate collective wisdom into new change efforts. Materials could be disseminated broadly on both public and private websites.
- A.4. Provide intensive at-the-elbow support to small clinics, independent clinics, and clinics working with vulnerable populations as top priority; These clinics and larger health systems should be challenged to share their expertise with each other so the effective approaches that have been developed in smaller and larger systems as well as systems that work with vulnerable populations can be spread.
- A.5. Build the will, buy-in, and capacity for change with stakeholders in the primary care community through strategic communications and consistent messaging about the benefits of PCPCH implementation, stories of positive experiences and successes of early adopters, and information about impact on quality of care and increased office efficiency. Communications and QI professionals need to make explicit the linkages between practice changes and the PCPCH Standards. This will help clinics see how different initiatives are connected and not isolated. This could help to reduce feeling of being overwhelmed by healthcare transformation efforts.

Key Considerations for PCPCH Transformation

- Ability of clinics to identify subpopulations of patients that need interventions
- Use of practice extenders and other non-traditional team members
- Clarification of care team roles and accountabilities including the patient and family roles on the team
- Care coordination and panel management
- Capacity of clinics to implement and sustain change that improves patient experience and health –change fatigue can occur and is a real concern

II. Leadership Development and Patient Engagement Workgroup

LEADERSHIP DEVELOPMENT

It cannot be underestimated how extremely critical effective leadership is to the successful implementation of primary care homes. A lack of leadership within a clinic will impede transformation and impact long-term sustainability of any positive changes made.

Characteristics of a Transformational Leader

- Strong background in change management strategies
- Has compelling vision of a shared future – inspiring others
- Effectiveness in the "Why We Are Doing This" communication with diverse stakeholders
- Works side by side with staff as they get started on practice changes
- Ability to facilitate and tell stories effectively, both to engage people to start building momentum
- Proponent of team-based approach and ability to model appropriate behaviors that build team competence and confidence such as delegation and sharing success
- QI and process improvement skills
- Engaged problem solving coach – The value of being directly involved with clinic staff and patients/families is critical for transformational leaders

The difference between traditional clinic management skills and the transformational leadership skills needed during this transition to PCPCH are significant. Specific technical skill levels are highly variable across organizations and geographically. While there are examples of exemplary leaders throughout the state, there is a significant variation in both their capacity to undertake a mentorship role and skills to do so.

In interviewing executives and managers who have been successful in implementation of PCPCH, their key learning was that PCPCH transformation had to be the top priority of the organization and not an afterthought. Across the sites, individuals have underestimated the amount of attention a leader must pay to this work. Effective leaders work closely with project managers and are a visible in the clinic setting. While there are many notable and strong healthcare management programs across the state, most have not integrated this work into their leadership tracks. Fostering learning opportunities and formalizing these skills in academic curriculum is an important strategy to sustain the change.

Priority Recommendations for Leadership Development

B.	**Identify a cadre of "Transformational Leaders" to act as mentors for others in state and utilize their experience to engage others.**
C.	**Create a healthcare transformational leadership development program –** Collaborate with professional associations and other key partners such as the Oregon Healthcare Workforce Institute, Health Leadership Taskforce, OHSU MBA program, OHSU MPH Program, and the American Leadership Forum.

PATIENT ENGAGMENT

The Patient-Centered Primary Care Home Standards are built on the fundamental foundation of whole-person and family-centered care. Most healthcare professionals will say they and their organizations are already "patient-centered" and tend to focus on making practice changes that are system-centered. Patient and family-centered care is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. It fundamentally redefines the relationships in health care. This approach shifts the focus of traditional *"doing to and for"* patients and families to **working *with* them**. It embraces the approach of ***partnering with patients and families*** at all levels of health care transformation and redesign.

Core Concepts of Patient and Family-Centered Care

Dignity and Respect - Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
Information Sharing - Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
Participation - Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
Collaboration -Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation and evaluation, in facility design, professional education, as well as in the delivery of care.

Due to the perception that "we are already patient-centered," there is a strong likelihood that technical assistance opportunities in this area might be overlooked by providers as a "nice-to" but not essential element in primary care redesign. Immediate pressure on the clinics to meet initial standards could preclude them from involving patients and families in practice redesign and other meaningful policy and program development collaboration. The workgroup believed this would be a significant oversight that turned "patient-centered" into a hollow catch phrase.

Priority Recommendations for Patient Engagement

D. Develop "Transformation Teams" - These teams could help with PCPCH Recognition and technical assistance in the clinic setting and would be made up of patient advisors, QI professionals and clinicians experienced in PCPCH to act as technical advisors. This would require some coordination and aligning efforts but would yield a high return for the investment. This effort would be seen as more credible if it was a partnership between NWHF and OHA.

E. Build a common framework for *patient-centeredness* – Engage with key leadership in the state to explore ways to integrate the involvement of patients and families into implementation of primary care homes. Explore interest in sponsorship to bring an intensive targeted seminar to Oregon through the Institute for Patient and Family Centered Care.

F. Create PCPCH materials and outreach efforts for patients and families – To promote partnerships, invite patients, families, community groups, and key consumer groups to participate as advisors in creating/reviewing materials. Sending consistent messages about PCPCH and providing tools for providers to engage patients will help build interest and engagement among the population.

III. Clinic and Virtual Care Teams Workgroup (Including Behavioral Health Integration)

CARE TEAMS

Team-based care within a PCPCH is a fundamental shift from the traditional model of primary care where the physician is responsible for delivering all patient care to a model where a team of healthcare professionals and para-professionals work together with clearly defined roles to provide an array of services that meets the needs of each patient. Creating teams within primary care homes that include team members not physically housed in the same building is a daunting task; however, linking clinical teams to community resources is key for PCPCH implementation success. Also, team development does not just happen by putting people together and calling them a team. It requires communication and role clarity, as well as tools that help team members be successful in their new roles. Considerable training, technical assistance, tools, and coaching are needed to make this transformation. However, these resources will yield significant results and promote the development of new partnerships that help ensure access to seamless and culturally/linguistically appropriate prevention and care services for patients, families, and communities.

Priority Recommendations for Clinic and Virtual Care Teams

G. **Address barriers to implementation and connect with opportunities to build on existing statewide groups -** An example is the hospice regulations that may be barriers to achieving the Standards for some rural communities. An example of building on existing statewide groups would be for the OHA to link concerns about non-traditional workers to the appropriate workforce standards subcommittee.

H. **Provide technical assistance and tools to help primary care clinics effectively manage the transformation** - Examples of TA include providing information for how to adjust panel sizes, TA activities to assist clinics in understanding their new roles as part of a team, and shared decision making.

I. **Inventory, create, and facilitate community linkages and learning –** Through the PCPCH Institute, facilitate learning networks and sharing of best practices, provide technical assistance on care coordination models, transitions of care, shared service agreements between clinics and other providers, and establishing relationships with community resources and other prevention and wellness initiatives, as well as help building them into workflow/referral processes.

The group identified the lack of reimbursement for non-traditional workforce as a major barrier to successful implementation of care teams. Also, the clinics will need on-site care coordination and guidance for integrating these new team members. Lastly, the group recommended that health plans explore how they could partner differently with primary care - Could health plans move their case management resources into the clinics to provide a physical presence or could health plans share the cost of the one person in a clinic that serves many regardless of insurance?

BEHAVIORAL HEALTH INTEGRATION

As the workgroup considered the PCPCH Standards, behavioral health integration became a major focus of its discussion. There are a number of areas that need attention if integration and collaboration between primary care and behavioral health is to move forward. The delivery model for primary care and behavioral health are

very different. Their diverse perspectives need to be integrated and appreciated in order for the patient to benefit by their closer interaction. The recommendations and discussion of the task force centered on how best to support this transition.

Another issue identified by the task force was the age-old discussion around confidentiality between behavioral health and primary care. Some primary care providers that have integrated behavioral health have taken the approach that mental health records are a part of the physical health records and let patients know that upfront. Others take a more conservative but far less coordinated position, requiring that mental health records are separated from physical health. Federal laws regarding the "protected class" for patients with behavioral health or substance abuse issues can be a barrier to the ongoing care coordination between primary care providers and behavioral health specialist. OHA can provide assistance with barrier removal, help build consensus, and provide clarification.

Priority Recommendations for Behavioral Health Integration

J.	**Increase the capacity of behavioral health professionals to provide services in primary care homes -** Provide training opportunities for existing behavioral health professionals to develop competency in a brief therapy intervention model geared to primary care settings. There is a serious shortage of behavioral health clinicians who have the training and skills necessary to work within a primary care setting.
K.	**Broadly disseminate screening and assessment tools and train primary care providers and staff how to implement in clinics** (e.g. SBIRT for substance abuse).
L.	**OHA take a leadership role to address barriers to behavioral health integration –** Provide clarification around sharing of confidential behavioral health information while minimizing documentation and data burden.
M.	**Facilitate collaborations between behavioral health and primary care -** Facilitate conversations between behavioral health and primary care to build relationships that promote the integrated model.

IV. Data Support Workgroup

The PCPCH Standards require clinics to have the capacity to capture data, report on it, and use it to improve care. This does not necessarily require an EHR, and even in some cases EHRs do not provide a registry function for the tracking of both preventive and chronic disease management. Many of the larger clinics within Oregon have developed data analytic competency because of their business needs. However, smaller clinics may not have this capacity and require technical assistance and options for shared infrastructure may be necessary to help these clinics meet the PCPCH Standards, especially in the must-pass areas.

There is dynamic tension between the Meaningful Use expectations and the implementation of PCPCH. While there is some overlap between these initiatives, they are experienced as competing demands instead of aligned priorities. Most practices have limited capacity and varied appreciation of the benefits of each. Timeframes for receiving financial incentives for Meaningful Use are driving many providers to choose EHRs while others are questioning the economic and business benefit of making investments to transform their practices. Providers

are most interested in the meaningful exchange of information to improve patient care, which is called out in Tier 3 Standards, so messages around benefits of PCPCH implementation should focus on this area.

Economic pressure exists to reduce hospital readmissions and inappropriate ED visits, especially for patients served by Medicaid. However, robust systems that provide real-time, useful, and actionable data in a standardized format are not generally available, and are essential for improvement in this area.

Priority Data Support Workgroup Recommendations

N.	**Convene a statewide group of healthcare stakeholders to reach consensus on how to provide primary care providers with real-time actionable data on patients who inappropriately use the ED or are admitted to the hospital for ambulatory sensitive conditions.**
O.	**Provide assistance to all clinics in developing data competency skills and embedding population registries.**
P.	**Provide a standard patient satisfaction tool and mechanism for collecting clinic data.**

Conclusion

It is evident that a significant leveraging of resources will be needed throughout Oregon for widespread adoption of the Patient-Centered Primary Care Home model. However, the recommendations provided by the task force create a compelling vision and detailed roadmap for achieving the goal of giving 75% of Oregonians access to a recognized Patient-Centered Primary Care Home by 2015.

Oregon is rich with existing expertise and resources to build upon, but coordinating these efforts and strategically focusing on the greatest areas of need will be critical in order to achieve maximum uptake. This will ultimately be the value of the Patient-Centered Primary Care Home Institute and technical assistance strategy. Through collaboration, innovation, and sharing of resources we can continue to build on the various healthcare transformation efforts to create a renewed primary care delivery system that provides better health, better care, and lower costs.

APPENDIX A: Task Force and Work Group Membership

Name	Organizational Affiliation	Area of Expertise	City
	Task Force Members		
Mary Minniti	*Facilitator*		*Eugene*
Patty Black	PeaceHealth Medical Group	Patient Advisor	Eugene
Laura Brennan	CareOregon	Community Collaboratives	Portland
Maria-Elena Castro	Providence Memorial Hospital	Diversity/Cultural Competence	Hood River
Tatiana Dierwechter	Benton County Public Health Department	Public Health	Corvallis
Stephanie Dreyfuss	Providence Health Plans	Health Plans	Portland
L J Fagnon	Oregon Health & Science University - Oregon Practice Based Research Network	Rural Practice	Rural
R J Gillespie	Oregon Pediatric Improvement Partnership/The Children's Clinic	Pediatrics/Quality improvement	Portland
Joe Hromco	Western Psychological & Counseling Services	Behavioral Health	Portland
Susan Kirchoff	Multnomah County Health Department	Safety Net Clinics/Health Depts.	Portland
Sarah Kooienga	Oregon Nurses Association/ The Willamette Clinic	Primary Care	West Linn
Pat Kuratek	HealthMatters of Central Oregon	Care Coordination	Bend
Carla McKelvey	Oregon Medical Association/North Bend Medical Center	Pediatrics/Physician Leader	Coos Bay
Mike Morgan	CareOregon Patient Advisor	Patient Advisor	Portland
Becky Pape	Samaritan Lebanon Community Hospital	Hospital Executive/OHA Board member	Lebanon
Dan Paulson	Springfield Family Physicians	Family Medicine	Springfield
Liz Powers	Winding Waters Clinic	Family/Rural Medicine	Enterprise
Evan Saulino	Oregon Academy of Family Physicians	Family Medicine/Physician Leader	North Coast
Kathy Savicki	Mid-Valley Behavioral Care Network	Behavioral Health	Salem
Jennifer Stephens	Oregon Nurses Association/Rural Primary Care Clinic	Rural Primary Care	Dexter

Workgroup Contributors			
John Allcott III	Applegate Medical Associates	Internal Medicine/Family Practice	Veneta
Clayton Gillett	OCHIN - Oregon Health Information Technology Extension Center	Information Systems/Data	Portland
Bruce Gutelius	Public Health, Oregon Health Authority	Population Data	Portland
Lori Lambert	Quality Corp	Measurement	Portland
Mindy Stadtlander	Multnomah County Health Department	Data Analytics	Portland
Craig Hostetler	Oregon Primary Care Association	QI - Safety Net Clinics	Portland
Elizabeth Takahasi	Multnomah County Health Department	Diversity/Cultural Competence	Portland
Kelly Volkmann	Benton County Public Health	Community Health Workers	Corvallis
Dawn Bonder	OCHIN O-HITEC	Quality Improvement	Portland
Summer Boslaugh	Quality Corp	Patient Engagement	Portland
Kathy Schwartz	Mid-Columbia Medical Center	Primary Care	The Dalles
Susan Chauvie	OCHIN - Oregon Health Information Technology Extension Center	Quality Improvement	Portland
Mylia Christensen	Quality Corp	Quality Improvement	Portland
Jill Currey	Oregon Health and Science University	QI - Rural clinics	La Grande
Noelle Wiggins	Multnomah County Health Department	Community Health	Portland

APPENDX B: Complete List of Task Force Recommendations and Strategies by Workgroup

I. Quality Improvement and Change Management Recommendations:

A. Establish a PCPCH Institute and technical assistance (TA) strategy:

Building Will:

- A.1. Leverage the expertise and success already taking place in Oregon. Our state is well-connected with national collaboratives and there is extensive quality improvement (QI) expertise across a number of organizations. However, there is no coordinating mechanism among the various efforts and no venue where organizations can share learning and build upon their collective wisdom.
    - A.1.i. Explore participation as a state in the National Patient Centered Medical Home Institute
    - A.1.ii. Build on CareOregon and others' experience in implementation of PCPCH. Explore CareOregon's curriculum modules currently being pilot tested beginning in October 2011 as possible prototype for widespread use in collaborative learning communities across the state. Modules include: empanelment, setting up a team, workflow, using the medical data system effectively, leadership-culture building, how to use data for process improvement, reorganizing work to achieve clinical outcomes, etc.
- A.2. Understand the current environment by assessing clinic readiness. It will then be possible to create a strategic plan with effective interventions to move clinics along the continuum of transformation. Target the development of QI knowledge in areas where gaps exist and where access to resources is limited.
    - A.2.i. Assess a clinic's adaptive reserve through the use of a measurement tool TransforMed Clinician Questionnaire
    - A.2.ii. Encourage the developing Coordinated Care Organization (CCO) players, associations and networks in each community to map the current state of implementation and interest in their areas among clinics and stakeholders
- A.3. Collect and disseminate a package of TA resources available broadly to clinics and others. This would be accomplished by convening a collaborative of QI experts/organizations in Oregon to identify standard best practices and leverage resources to continually integrate collective wisdom into new change efforts. Materials could be disseminated broadly on both public and private websites.
    - A.3.i. Expand QI knowledge within healthcare organizations by offering virtual educational strategies: webinars, dissemination of toolkits and other virtual methods
    - A.3.ii. Be explicit in training on the Plan-Do-Study-Act cycle of small tests of rapid change
    - A.3.iii. Engage community colleges, technical training institutions, OHSU School of Medicine, Nursing, COMP-Northwest, etc. to add QI and Change Management skill building into their curriculum.
- A.4. Provide intensive at-the-elbow support to small clinics, independent clinics, and clinics working with vulnerable populations as top priority; These clinics and larger health systems should be challenged to share their expertise with each other so the effective approaches that have been developed in smaller and larger systems as well as systems that work with vulnerable populations can be spread.

    - A.4.i. Identify shared resources to bring expertise into communities. Encourage that their costs be shared across clinics, so that expertise can be accessible in all communities.
- A.5. Build the will and buy-in with stakeholders in the primary care community through strategic communications and consistent messaging about the benefits of PCPCH implementation, stories of positive experiences and successes of early adopters, and information about impact on quality of care and increased office efficiency. Communications and QI professionals need to make explicit the linkages between practice changes and the PCPCH Standards. This will help clinics see how different initiatives are connected and not isolated. This could help to reduce feeling of being overwhelmed by healthcare transformation efforts.
    - A.5.i. Utilize associations and professional organizations for the differing professionals to help disseminate information broadly. Identifying materials and preparing the dissemination materials could be a function of the state and/or a foundation.
- A.6. Remove barriers that would prevent participation or interest in PCPCPH adoption, especially in area of behavioral health integration.

II. Leadership Development and Patient Engagement Recommendations:

<u>Leadership Recommendations:</u>

B. Identify a cadre of "Transformational Leaders" to act as mentors for others in state and utilize their experience to engage others

- B.1. Establish a Speaker's Bureau
- B.2. Develop a mentorship connection for leaders to connect with a new and/or emerging leaders
- B.3. Develop residency/internship opportunities for physicians in PCPCH settings that have strong role models
- B. 4. Identify and/or develop Tips and Tools for Transformational Leaders: A Getting Started Primer (How to create an environment of change – balancing urgency with long term strategies)

C. Create a healthcare transformational leadership development program – Collaborate with professional associations and other key partners such as the Oregon Healthcare Workforce Institute, Health Leadership Task Force , OHSU MBA program, OHSU MPH Program , and the American Leadership Forum

- C.1. Seek professional associations to contribute to the Healthcare Transformational Leadership Program's development and support its operations. Develop both Executive Leaders and Front Line Leaders tracks.
- C.2. Provide scholarships to statewide leadership program for small clinics to send front line leaders. This can be part of a succession plan for small clinics that can be negatively impacted when a seasoned leader retires or leaves practice.
- C.3. Establish a fund available to small rural practices that allows for locum-tenums to replace physicians while they participate in learning sessions.
- C.4. Consider training pool of locum-tenums as change leaders that can serve dual purpose when deployed to various clinics.

- C.5. Embed transformational skills in the curriculum of all healthcare disciplines including clinical and administrative roles - Collaborate with institutions in Oregon that provide degrees/certificates for healthcare professionals to make this change quickly. Identify how to encourage this change occur in a timely fashion.

Patient Engagement Recommendations:

D. Develop "Transformation Teams" - These teams could help with PCPCH recognition and technical assistance in the clinic setting and would be made up of patient advisors, QI professionals and clinicians experienced in PCPCH to act as technical advisors. This would require some coordination and aligning efforts but would yield a high return for the investment. This effort would be seen as more credible if it was a partnership between NWHF and OHA.

E. Build a common framework for *patient-centeredness* – Engage with key leadership in the state to explore ways to integrate the involvement of patients and families into implementation of primary care homes. Explore interest in sponsorship to bring an intensive targeted seminar to Oregon through the Institute for Patient and Family Centered Care.

- E.1. Engage leadership among the state associations in expanding their definition of patient-centered to align with the best thinking across the country. Bringing in national experts like Beverley Johnson, CEO and President of IPFCC for membership meetings and/or conferences. This educational intervention can help raise awareness of the depth and power of meaningful partnerships with patients and families.
- E.2. Tap into the expertise in the state through Quality Corporation and the organizations involved in the Patient and Families as Leaders Learning Network to act as mentors and guides for other organizations in their implementation of the Patient-Centered part of their primary care home implementations.
- E.3. Engage state groups like the Oregon Academy of Family Practice to host webinars on patient engagement for their membership.
- E.4. Offer a modified Seminar on Advancing the Practice of Patient and Family-Centered Care in Oregon targeted at primary care sites. Identify key organizations including CareOregon, Providence, PeaceHealth and local foundations that might become sponsors of this two day targeted seminar. The Institute for Patient- and Family-Centered Care works with organizations taking a leadership role in this area. Organizations can become pinwheel sponsors by helping offset the cost of bringing national faculty to our state for a seminar experience. Seek funding to provide scholarships for seminar participation to small practices and others who might not be likely to attend due to costs.

F. Create PCPCH materials and outreach efforts for patients and families – To promote partnerships, invite patients, families, community groups, and key consumer groups to participate as advisors in creating/reviewing materials. Sending consistent messages about PCPCH and providing tools for providers to engage patients will help build interest and engagement among the population.

- F.1. NWHF can support efforts to build a network of patient and family advisors across the state by encouraging their grantees to involve patients and families in program redesign and quality improvement.

- F.2. Highlight and promote patient and family engagement resources [both written guides and video] available to organizations for in-services at clinics on-site. Some materials are available through Quality Corporation as part of their Patients and Families as Leaders Initiative with RWJF.
- F.3. Integrate the use of expert faculty on patient- and family-centered care and the effective use of advisors during primary care transformation in existing and new collaborative initiatives. This model was used by the California Health Foundation in their Team Up for Health Initiative.
- F.4. Convene a group of patient and family advisors from mental health as well as primary care to help develop outreach materials for patients/families and the community on the benefits of PCPCH and their role in the new care team model. Utilize the research and materials developed in Minnesota by a similar group, focusing this group's efforts on adapting it to meet our cultural and unique Oregon needs.
- F.5. Use storytelling from trusted credible messengers to advocate for the value proposition of PCPCH and ensure that it is sensitive to literacy, language, and cultural needs.

III. Clinic and Virtual Care Teams Recommendations:

Care Teams Recommendations:

G. Address barriers to implementation and opportunities to build on existing statewide groups.

- G.1. Encourage OHA to review and address the hospice regulation issues that are seen as barriers to meeting hospice related standards for some rural communities
- G.2. Explore requirements for health plans to align payment incentives to meeting PCPCH standards - OHA could work with the Insurance Commissioner
- G.3. Encourage OHA to take a leadership role in coordinating the different state departments that impact primary care and community health and serve as a convener to ensure changes don't negatively impact primary care and prevention services for patients and families
- G.4. Encourage OHA to link the concerns about non-traditional standards and licensure to the appropriate workforce standards group including:
    - G.4.i. Recommend standards be adopted for non-traditional workers and engage training institutions in identifying basic competencies/knowledge to inform workforce development and future reimbursement
    - G.4.ii. Provide licensure information, boiler plates for job descriptions and sample role descriptions for non-traditional roles like CHW, PDS, etc. and distribute broadly to clinics and communities

H. Provide technical assistance and tools to help primary care clinics effectively manage the transformation. Below is a list of tools identified to assist the clinics:

- H.1. Make widely available a technical description of how to adjust panel sizes for practices and to understand supply/demand in a clinic environment.
- H.2. Provide self-administered practice assessments that help clinics evaluate their strengths and gaps in meeting the PCPCH Standards

- H.3. Continue to support and provide resources at the state level for chronic disease self-management patient education (The LiveWell Program)
- H.4. Develop or identify team development activities/TA that assist clinics in expanding the skills of their team and understanding the roles of non-traditional positions
- H.5. Provide Shared Decision Making technical assistance

I. Inventory, create, and facilitate community linkages and learning.

- I.1. Develop a facilitated learning network to promote PCPCH implementation support and sharing of best practices (i.e. Regular state-wide calls, TA assistance by phone, etc.)
- I.2. Provide technical assistance on standards/best practice for transitions of care
- I.3. Develop a template for service agreements between clinics and other providers and a recommended process for creating them. (i.e. Colorado Medical Society Contracts and Facilitative Guide)
- I.4. Provide information about shared service models like HealthMatters, ORPRN, etc. to communities.
    - I.4.i. Encourage the CCOs development committee to build a requirement that CCOs provide that function in their communities for clinics whose size prohibits their effective utilization of resources such as care coordinators, community health workers, etc.
- I.5. Provide TA on Care Coordination Models– could partner with the High Value Pilot learning leaders, Care Management Plus, HealthMatters

<u>Behavioral Health Recommendations:</u>

J. Increase the capacity of behavioral health professionals to provide services in primary care homes – To address the workforce shortage, provide training opportunities for existing behavioral health professionals to develop competency in a brief therapy intervention model geared to primary care settings. The current workforce is trained to provide therapy in a 50-minute, closed-door approach versus what is needed in primary care settings - 20 minutes per patient and specific skills for treating the behavioral aspects of physical health conditions.

- J.1. Convene a distance learning group from Oregon to spread costs and encourage participation across the state
- J.2. Sponsor tuition for behavioral health providers or bring training to Oregon

K. Broadly disseminate screening and assessment tools and train primary care providers and staff how to implement in clinics (e.g. SBIRT for substance abuse).

- K.1. Develop or locate of a set of tools for behavioral health in primary care settings that includes scripts for how to talk to patients, motivational interviewing skills, and video examples
- K.2. Disseminate the Integration Toolkit from March, 2009 from the State of Oregon Addictions & Mental Health Division to provide information on integration and specifically on screening tools, as well as recommendations from the joint effort of the Oregon Pediatric Society and Oregon Council of Child & Adolescent Psychiatry's (aka Oregon Children's Mental Health Task Force).

L. OHA take a leadership role to address barriers to behavioral health integration – Provide clarification around sharing of confidential behavioral health information while minimizing documentation and data burden.

- L.1. Ensure the documentation is consistent amongst provider types in an integrated setting
- L.2. Ensure that any community health worker certification, regulatory framework, payment structure, etc. include mental health peer wellness
- L.3. Support the OPAL-K initiative - Oregon Psychiatric Access Line for Kids, a joint project of OCCAP, OPS and OHSU.
- L.4. Develop a global payment for psychiatric consultation to primary care (does not include face-to-face with patient). When primary care can be assured that 1) they can obtain consultation advice from a psychiatrist when needed and 2) quicker access to specialty care with truly difficulty cases, they will significantly decrease their referrals to specialty psychiatry.

M. Facilitate meaningful collaborations between behavioral health and primary care clinicians to build relationships that promote the integrated model.

- M.1. Develop or locate a set of questions (facilitative guide) that would help facilitate partnerships with primary care and behavioral health professionals. These questions would form an outline on how to understand the specific value each brings to patients in pursuit of health improvement. The purpose of the guide would be to provide an opportunity to build bridges and facilitate strong working relationships in each community.
- M.2. Develop or locate a brief primer on the components of behavioral health services, disciplines (e.g., psychiatry, psychology, social work, etc.), Medicaid vs. commercial vs. Medicare systems for behavioral health, etc.

IV. Data Support Workgroup Recommendations:

N. Convene a statewide group of healthcare stakeholders to reach consensus on how to provide primary care providers with real-time actionable data on patients who inappropriately use the ED or are admitted to the hospital for ambulatory sensitive conditions.

O. Provide assistance to all clinics in developing data competency skills and embedding population registries. Strategies to build this capacity:

- O.1. Leverage the Meaningful Use environment to drive decisions that will support population management and effective utilization of scarce resources.
    - O.1.i. Help clinics not currently on an EHR to understand the importance of registry functions that are needed to effectively change primary care outcomes. Provide a short list of products that effectively integrate these functions into the EHR.
    - O.1.ii. For those sites not yet committed to EHR adoption, provide information about vetted registry products that would be a short-term solution to this needed function. Access the California Health Foundation report and approach to this work.
- O.2. Direct resources and attention to create meaningful infrastructure that allows clinics to meet the Tier 3 standard for electronic health information exchange.
    - O.2.i. Make this recommendation part of the conversations now occurring about the role of CCO's supporting PCPCH in their geographic regions - "PCPCH shares clinical

information electronically in real time with other providers and care entities (electronic health information exchange)"

- O.3. Provide information and assistance to clinics to promote the use of data registries which would provide choices based on their readiness and willingness to spend resources
    - O.3.i. Provide an excel prototype registry with a facilitated guide on how to set up a registry for a practice. Provide technical assistance for sites that choose this as an option.
- O.4. Provide implementation assistance for extracting data and technical assistance to clinics on how to use data for improvement – citing examples such as CareOregon's work in the Portland Metro area as a model
- O.5. Build on the aggregated claims data provided by Quality Corp and available through a web-based portal. This has been utilized by larger clinics and data will be available to smaller practices in the near future.
- O.6. Encourage clinics to take a tiered approach to the utilization of data to drive change. Their initial focus should be on improvement in those areas where the evidence shows specific interventions result in reduction in morbidity/mortality, reduced cost. [i.e. Diabetes, heart failure]
- O.7. Develop creative public/private partnerships with community wide data that can leverage information useful to a community and at a clinic level. There are two databases provided at the state level: Hospital discharge Index and the Prescription Drug Monitoring Program. Developing reports that are timely about patients on controlled medications that are at risk for abuse and/or more appropriate care coordination for pain management support would be very useful to the practicing clinician. It is because timely data is not available that providers cannot identify possible patient misuse of controlled substances and drug seeking behaviors from those patients whose pain in not yet appropriately controlled. In the absence of data, often all patients are labeled "drug seekers" and don't receive appropriate interventions. A similar pilot could be undertaken across a community to illuminate opportunities for PCPCH improvement in the area of ambulatory sensitive care hospital admissions. This could help a community as well as PCPCHs in the area to identify a gap in primary care interventions. Pilot this use of state data in a community where hospitals and clinics collaborate on a shared approach to the data in these registries.

P. Provide a standard patient satisfaction tool and mechanism for collecting clinic data.

- P.1. Develop a short term solution for patient satisfaction: Standardize a satisfaction tool across state, make available in a web-based solution and/or access data base and provide a technical assistance guide on how to use the date to drive improvement efforts. State could aggregate data every quarter across regions and broadly communicate learning and opportunity within regions. Adapting the CAHPS visit based survey to a web-based solution would align all clinics in the same direction.
- P.2. For the long term, convene health plans, state and others to explore possibility of creating statewide infrastructure to assist in collecting CAHPS data.