



Patient-Centered Primary Care Home Program Update

July 2019

New in Research: Reducing provider burnout in medical homes

Motivated and engaged providers are at the heart of any successful primary care home. But despite the positive outcomes of the medical home model, the stress inherent in transforming into a high-functioning and quality-driven clinic runs the risk of increasing provider and staff burnout which has been associated with adverse consequences for patient care.



A recent study assessed the impact of staff participation in quality improvement on morale during the implementation of the medical home model within the Veterans Health Administration. It found that providers and staff involved in Evidence-Based Quality Improvement (EBQI)—an approach that promotes cross-discipline, data-driven problem solving in local primary care practices—experienced less emotional exhaustion and job dissatisfaction over time than those without this exposure. In other words, when front-line providers and staff were the ones proposing and approving innovations projects or process improvements, they were less likely to experience burnout.

Researchers have suggested a couple different reasons as to why staff morale may benefit from increased engagement in medical home implementation. Medical home-related problems or challenges may be solved more quickly in practices that engage in EBQI as staff help to drive system redesign or other types of quality improvement innovations (including those directly aimed at addressing burnout).

“Healthcare systems should consider EBQI as a systematic method for assisting with large organizational changes, such as medical home implementation.”

Full Publication: Meredith, L., Batorsky, B., Cefalu, M., Darling, J., Stockdale, S., Yano, E., & Rubenstein, L. (2018). Long-term impact of evidence-based quality improvement for facilitating medical home implementation on primary care health professional morale. *BMC Family Practice*, 19:149. <https://doi.org/10.1186/s12875-018-0824-4>

Extra Guidance for Standard 5.C.3 – Individualized Care Plans

Patients with complex medical and social needs face significant barriers when navigating medical recommendations and treatments within an often-complicated health care system. This is why Standard 5.C.3. is awarded to clinics that develop whole-person, individualized written care plans for these patients to help coordinate and integrate their care.

Beyond an automated “assessment plan” portion of an after-visit summary, individualized care plans take patient-focused care to the next level by including self-management goals, goals of preventive and chronic illness care, and an action plan for exacerbations of chronic illness. Generic goals such as “decrease A1C” are not considered as meeting the intent of this measure since they are not patient-focused or actionable. Rather, these care plans are developed collaboratively with each patient and address their unique circumstances. Examples of individualized action plans may include “walk to work three days a week” or “sign up for this local produce distribution program by next visit.” Designed to be used as a tool by the patient or caregivers themselves, they are written in patient-friendly language and provided in a format that is accessible.



In addition to these aspects of the care plan itself, it is important that care planning be understood by staff across the clinic. Lack of awareness or understanding of the intent and nature of these plans among staff can make it difficult for patients to navigate their care even with a plan. As implied by its placement in the model, the ultimate goal of this standard is to increase **coordination** and **integration** of care. Finally, though it may require a couple extra steps, clinics with limited EHR functionality can meet the standard as well by creating a care plan template (ex: in word) and, after completing it with a patient, scanning it into their chart and giving them a copy.

[Patient-Centered Primary Care: Care Plan Development](#) guide is a comprehensive resource for any clinic looking to pursue or improve their care planning process. Further details about Standard 5.C.3 can be found on pages 82-85 of the [PCPCH Technical Assistance Guide](#). And as usual, PCPCHs are welcome to email the program at pccph@dhsola.state.or.us for general questions about PCPCH standards.

Resources for work around the social determinants of health

Innovation Café Materials:

Materials from the recent Innovation Café are now posted on the Transformation Center website. The event focused on strategies to address social determinants of health, particularly housing, trauma, early learning/early childhood education and food insecurity. Resources include plenary slides and handouts from the 45 projects that were presented by CCOs and community partners from across the state. See the materials at <http://www.oregon.gov/oha/HPA/dsi-tc/Pages/Innovation-Cafe.aspx>.

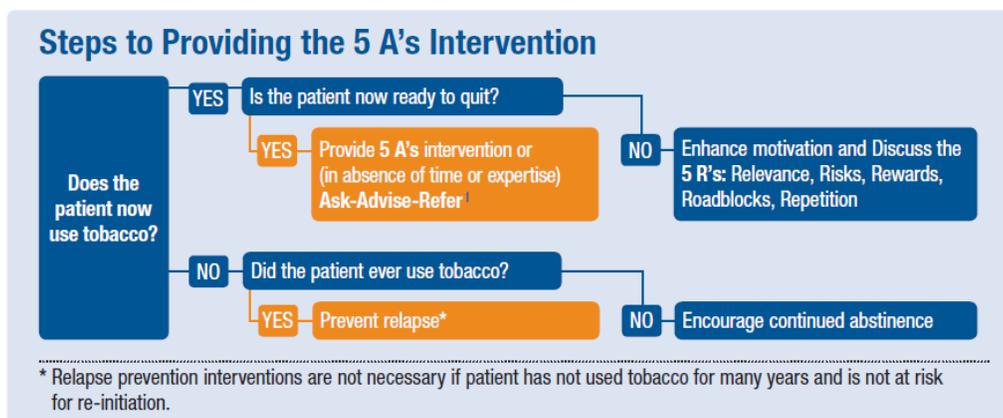
Transformation in Action newsletter:

The new summer issue of the Transformation Center's Transformation in Action newsletter highlights some of the innovative ways six communities are addressing social determinants of health. The community-level strategies highlighted include:

- Sustainable funding model for social determinants of health
- SNAP match program at farmers markets
- Changing zoning codes to spur tiny home development
- County-wide childhood trauma informed networks
- Regional kindergarten readiness network
- Investments in community infrastructure

See the archive and sign up for future issues at <https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-in-Action.aspx>

Tobacco cessation resources



The Oregon Health Authority has released a brief **Tobacco Cessation 5 A's Guide** based on the Agency for Healthcare Research & Quality's national clinical guidelines for tobacco use intervention. This guide provides brief, clear steps for any care team member to deliver the 5 A's tobacco cessation intervention.

- English: <https://apps.state.or.us/Forms/Served/le2877.pdf>
- Spanish: <https://apps.state.or.us/Forms/Served/ls2877.pdf>

Free, quick online tobacco cessation counseling training (with CME)

What: This short online course will improve your care team's ability to help patients quit tobacco. The course focuses on Brief Tobacco Intervention and Motivational Interviewing techniques.

Who: All members of the care team committed to supporting their patients to quit tobacco.

When: The course is self-paced and takes approximately 45 minutes. The course can be started, paused and resumed later as needed.

CMEs: This training has been reviewed and is accepted for up to 1.0 prescribed credit from the American Academy of Family Physicians (AAFP). For other licensing boards that may not pre-approve continuing education credits (for example, the Board of Licensed Professional Counselors and Therapists), please submit the certificate of participation to your accrediting body.

Access the training: <https://tcrc.rapidlearner.com/3462253711>

Questions? Please contact Anona Gund (Anona.E.Gund@dhsola.state.or.us or 971-673-2832)

Coming Up: Events and Trainings

Training: Becoming a BHC to Advance Primary Care

More and more primary care clinics are integrating BHCs as essential primary care team members. As an emerging primary care role, BHCs often need additional training & a new practice community. The Interprofessional Primary Care Institute is offering a 3-day intensive training event that will:

- Provide BHCs an overview of primary care behavioral health skills & competencies
- Provide specific BHC training options to BH & medical directors to support on-boarding BHCs
- Facilitate the development of primary care BHC practice community in Oregon

Dates: August 15-17, 2019 from 8:00am to 5:00pm each day

Location: Newberg, OR

Cost for all 3 days:

- \$300 professional
- \$150 current students
- Buy 3 get 1 additional participant free (organization group rate)

Details & Registration: <http://www.pcpcci.org/events/becoming-bhc-advance-primary-care-training>

Webinar: Controlling high blood pressure (with no-cost CME)

The Transformation Center invites clinicians who serve Oregonians to a recorded free CME-accredited webinar focused on controlling high blood pressure. The webinar features Dr. Mark Backus, a Bend physician who was named a hypertension control champion by the Centers for Disease Control and Prevention Million Hearts® campaign.

When: Available on demand through September 20, 2019.

Webinar registration (includes pre-test questions for CME):

<https://attendee.gotowebinar.com/register/9066652441072643329>

More details: <https://www.oregon.gov/oha/HPA/CSI-TC/Documents/Controlling-High-Blood-Pressure-Webinar.pdf>

After this 1-hour presentation, participants will be able to:

- 1) Review CCO hypertension metric specifications
- 2) Explain the implications of the SPRINT blood pressure study and new American Heart Association guidelines
- 3) Illustrate the proper body position for taking blood pressure
- 4) Identify ways for providers to improve blood pressure control
- 5) Share strategies for clinics to improve blood pressure control
- 6) Describe how to identify patients who require referral or special testing for their hypertension

Questions?

We are here to help! Contact us at PCPCH@dhsoha.state.or.us.

About the Patient-Centered Primary Care Home Program

Patient-Centered Primary Care Homes (PCPCH) are health care clinics that have been recognized by the Oregon Health Authority (OHA) for their commitment to providing high quality, patient-centered care. The PCPCH Program administers the application, recognition, and verification process for practices applying to become Patient-Centered Primary Care Homes. The program is also working with stakeholders across Oregon to support adoption of the primary care home model. For more information visit www.PrimaryCareHome.oregon.gov.

The mission of the PCPCH Program is to be a trusted partner in primary care, collaborating with stakeholders to set the standard for trans formative, whole-person, and evidence-based care.