Are You Ready?

by L.J. Fagnan, MD, ORPRN Network Director

Healthcare change is happening and I want to leave you with two messages—1) future reimbursement will be based on your ability to use data for improvement, and 2) small practices need to be at the table in developing support for improvement. Are you ready?

In the March 5, 2015 New England Journal of Medicine, U.S. Secretary of Health and Human Services, Sylvia M. Burwell, announced that Medicare payments will move from a visit-based to a population-based formula. The intent is to meet the Triple Aim of improved health, lower per capita cost and better care. The goal is to have 85% of all Medicare fee-for-service payments linked to quality and value by 2016 and 90% by 2018. In addition, 30% of Medicare payments will be tied to quality or value through alternative payment models by the end of 2016 and 50% of payments by the end of 2018. You may be skeptical about the reality of the proposed payment changes, but change is happening and there is no stopping this train. Are you ready?

Patient-centered medical home initiatives, including payment reform incentives, will continue with the current rapid expansion trajectory. In Oregon we have over 900 primary care clinics; about half of these practices have attested as Patient-Centered Primary Care Homes (PCPCH). Payers are encouraging the PCPCH trend. In 2012 the Comprehensive Primary Care Initiative (CPC) was launched by the Centers for Medicare and Medicaid Services in collaboration with commercial and state health insurance plans in seven U.S. markets. The CPC program addresses the Triple Aim by supporting five ‘Comprehensive’ primary care functions—care management for high-risk patients, access, planned care, patient and family engagement, and coordination of care. Oregon is one of the seven markets with 67 primary care practices (552 clinicians) participating. ORPRN and Dr. David Dorr’s Care Management Plus (CMP+) program provide the regional faculty support for these practices. Oregon has responded to the Affordable Care Act with the (continued on page 3)
Focus on Quality Improvement: Finding Solutions Hidden in Plain Sight

by Ann Romer, MS

Proving bigger isn’t always better is the tight-knit group of staff at Aumsville Medical Clinic (AMC), a clinic with the Santiam Hospital system. Despite delivering high quality patient care, persistent small problems in various areas of the clinic prevented staff from feeling effective in their team work and care delivery. They set out to learn how to optimize their work so that they could feel empowered as a team to make needed improvements. Enlisting the help of Ann Romer, ORPRN PERC, the clinic hosted a pair of lunch-time meetings to first discuss how workflow analysis helps identify options for clinic optimization and solutions for current problems, and then engage in constructing a current state map of a clinic workflow (lab results communication) that included the roles of front and back office staff.

Development of a current state map revealed previously unknown steps across clinic functions (for providers and support staff alike) and identified a key bottle neck in the workflow that presented an opportunity for error reduction (standardization), improved efficiency, and increased staff satisfaction. The simple solution identified was in sync with quality improvement approaches like Lean and Kaizen which emphasize small, incremental change as the key to improvement. “Thinking big is overwhelming, but going smaller is helpful….this map has proven we can have better efficiency, even in small ways”, says Donna Hoag, practice manager for AMC.

Including all levels of staff is integral to achieving the conversations and coordination of efforts needed to identify and maximize opportunities for improvement. AMC now meets regularly through weekly huddles and monthly all-staff meetings to address clinic issues as well as review what is working well. As a participating clinic in the Comprehensive Primary Care initiative, they also leverage the resources of this nationwide pilot project to move towards more advanced patient-centered care.

Being a small clinic provides the advantage of making decisions as a group, while also heightening the importance of relating to each other as valuable team members. Sustaining a focus on quality improvement takes practice, but AMC staff recognizes gains can be made quickly and the effort can prove very validating.

Tell me and I forget. Teach me and I remember. Involve me and I learn – Benjamin Franklin.

Recent ORPRN Publications


Coordinated Care Organization (CCO) program. Sixteen geographically dispersed CCOs insure approximately one million Oregonian Medicaid enrollees (25% of the state population). Approximately 500 primary care practices and 43,000 primary care clinicians are in the CCO model. The state is tracking 17 CCO incentive measures with an additional 16 state performance metrics. These metrics along with cost and utilization data will measure state’s Triple Aim progress.

In meeting the Triple Aim, practices will increasingly be expected to collect and utilize quality metrics to improve population-based health as a core competency. Are you ready? What is the infrastructure for quality improvement (QI) in your practice? In recent conversations with clinicians and other health leaders in Oregon about presence of a robust QI infrastructure in small- to medium-sized practices, the response is “there is no infrastructure and furthermore, we do not know how to start.” This is not an unexpected response, given the day to day imperative of keeping up with a busy schedule of 15 to 30 minute patient visits from 8 A.M. to 5 P.M. that tacks on increasing amounts of time during lunch and after office hours to document the care.

Practice size is a factor in developing a robust quality improvement infrastructure. In spite of two decades of consolidation of health care market through health system expansion, small- and medium-sized clinics are the dominant form of primary care in the U.S. with more than 70 percent of family physicians practicing in groups of five or fewer. Although some of these physicians may be employed or integrated into larger delivery systems, their practices also experience time constraints, limited health information technology and data management resources, staffing shortages, and a lack of financial incentives as common barriers to practice-wide QI implementation.

In response to the increasing imperative to develop meaningful and sustained QI infrastructures, the Agency for Healthcare Research and Quality (AHRQ) created a grant program to fund eight regional cooperatives in the U.S. to study how to support the development of QI capacity in small- to medium-sized practices. The proposal called for a minimum of 250 primary care practices in a contiguous geographic region. Practice facilitation is a critical component of building this QI capacity.

ORPRN is well positioned to conduct this work. Over the last decade we have developed and sustained strong relationships with primary care practices across the state. Our practice facilitation model for practice improvement and practice change, using regional Practice Enhancement Research Coordinators (PERCs), has been highly successful. To meet the requirements, ORPRN has joined with the MacColl Center for Health Care Innovation and Qualis Health to form the Northwest Coalition for Primary Care Practice Support (NCPCPS). We anticipate an announcement in May that NCPCPS has been selected as one of the regional cooperatives. Beginning in the summer of 2015 NCPCPS will invite 130 small- and medium-sized Oregon primary care practices with 10 or fewer clinicians to participate. The project aims to address the Million Hearts Initiative (http://millionhearts.hhs.gov/) to improve cardiovascular health and prevent one million heart attacks by 2017. Using practice facilitation and data management, practices will improve cardiovascular risk factor measures: aspirin use, blood pressure and lipid control, and smoking cessation. Participating clinics will receive at least 18 months of practice support, health IT technical assistance, quality improvement coaching, academic detailing, and opportunities to participate in workshops to build QI competencies.

The ORPRN Steering Committee strongly endorsed ORPRN’s role in the project and their comments were reflected by Baker City family physician, Jon Schott, who stated: "Wow, we really need this support to make quality improvement happen in our practices. Let me know how I can help with getting word out."

To learn more or get involved, contact ORPRN at orprn@ohsu.edu.
Engaging Patients and Communities in Improving Health: An interview with Susan Lowe and Kristen Dillon

by Margaret Spurlock, MPH

Practice-based research networks, including ORPRN, are increasingly engaging patients and stakeholders in all phases of research—from setting research priorities to designing studies to disseminating results. Engagement offers the opportunity to make research more patient-centered, relevant to community needs and priorities, and likely to be adopted into practice. Margaret Spurlock, ORPRN’s Community Engaged Project Manager, interviewed Susan Lowe, consumer/patient advocate, and Kristen Dillon, family physician and ORPRN steering committee member, about patient engagement efforts in the Columbia Gorge region and what they’re learning from their experiences.

Margaret Spurlock: Why do you think patient engagement is important?

Susan Lowe: Because you have to have the whole picture, and without patient engagement you’re missing a piece. In order to have the full picture you’ve got to have all the players at the table.

Kristen Dillon: As a primary care clinician in practice I’m a prime consumer of health and health care research, and I’m not particularly satisfied with the quality of what I have to work with right now. I feel like the lack of engagement with consumers like me leads to a lot of research coming to conclusions that either aren’t relevant to most of the things that my patients need or that aren’t applicable because the research itself was so specific and sterilized.

MS: What role is patient engagement playing in some of the transformation and research efforts in the Gorge region?

SL: I’m part of the Community Advisory Committee, and that group got to allocate part of the transformation dollars, which was huge. I did a presentation at a statewide summit and other areas did not do that. In the Gorge, patient engagement is very much looked at and listened to.

KD: For me the experience with the Coordinated Care Organizations has built my motivation to do this work in clinical services and in research as well. It’s helped me see the hubris in those of us who provide the services thinking we know what the people we’re trying to serve need instead of building relationships to be able to ask them. Just seeing how well the process of integrating the consumer and community voice into the CCO has made me motivated to bring more of a spectrum of perspectives to health research.

MS: Have you seen changes to projects that may not have happened without patient engagement?

SL: I presented a proposal for Meals on Wheels for post-surgical and patients who are under the age of 60, and out of that has come a real need for nutritional value for people with mental health issues who are under the age of 60 who have multiple physical and mental problems. Because of the patient engagement in that process, the project has found that there’s a real gap in help for a particular population.

KD: We’re just getting ready to start work through the Knight Cancer Institute project to improve our structures for colon cancer testing in our community. I was meeting with a group of Latino health advocates, and it was really interesting to learn—as opposed to what we thought—they weren’t affirming that there are any sorts of bad rumors about colon cancer screening in the community. They just felt like they were completely unaware that it was the recommended test. They even reflected on the fact that they knew about mammograms and they know about Pap smears, but this was one that most of them had never heard about … They were saying “we think women are more comfortable talking about this with women than with men; so if you’re going to work with groups of people, maybe you should split up the men and the women.” That was an example of something that we wouldn’t necessarily have thought of ourselves, but based on the group dynamic and what people were observing could be really helpful in coming up with a better project moving forward.

MS: What are some things you’ve been learning through this work?

SL: I’ve learned a lot about primary care and how undervalued it is. I think from that perspective I’ve learned that the more educated patients and the community are, the better they can advocate for change.

KD: I think one of the things that needs to happen before you can have these types of dialogues is different groups of people need to be in relationship with each other, and it’s been interesting to experience how valuable it is for me to be here in the community not primarily in an academic center somewhere else. Even then, I’ve felt like I’ve needed adapt how I present things and try to go to the groups and the people we’re trying to reach instead of expecting them to come to us. The other thing that’s been surprising is that I’ve always felt that health research is a bit esoteric, and I’ve been really surprised by how quickly people understand why it matters to them and how enthusiastic the community has been about getting involved.

This interview has been condensed and edited.
But many clinicians have been thinking about oral health and primary care integration long before this formal process began.

For many years “medical” and “dental” have existed in siloes. Primary care clinicians and dentists work in separate offices, have separate patient records, have different ways of coding their work, and have even shared patients without ever actually talking to one another about the care that patient is receiving. Clinicians that are committed to integration are working on breaking down these siloes. So when you have two disciplines that have been so separate, where does one begin “integration”?

The path to integration will undoubtedly be complex. But the first step is becoming clear: communication. Dr. Jon Schott, a primary care physician in Baker City, has reflected on his work with Dr. Sean Benson, who for many years worked in a dental private practice in the same community. Dr. Schott and Dr. Benson were two of the few clinicians from the medical-dental realms who from early on adopted the idea of talking to each other about their patients. That communication was invaluable for effective follow-up and good care for their shared patients.

Dr. Benson is now working with the OHSU School of Dentistry developing their General Practice Residency program, which aims to place post-doctoral residents in medical settings to work as part of a multi-disciplinary team. He believes that, among many other benefits, this cultural exposure will help clinicians from diverse fields learn how to understand each other’s language and work together more effectively.

In the Columbia Gorge region, Dr. Elizabeth Aughney, the Dental Director of One Community Health (OCH), is working on population health to measure improvements in integration efforts, staffing for integration, and improving communication between medical and dental clinicians. For several years, OCH has been looking at high-risk groups (such as patients with diabetes and pregnant women) and tracking outcomes (such as the percentage with a comprehensive dental exam) as one measure of integration progress. Much of their success is owed to Community Health Workers, who are key players in connecting patients with medical and dental care. In 2015, medical and dental clinicians literally began sitting around the table together, by way of newly implemented meetings where clinicians from both fields can ask questions and educate each other on topics and approaches that might be unfamiliar to the other.

It seems like when we think about the mouth, it should not only be in how it is connected to the rest of our body, but in how using it can help us connect to others. A common hope among the early adopters of integration is that we can ingrain this habit of communication into the minds of future leaders in healthcare, through innovate training programs, cultural exposure, and creating space for conversations.

Using the Emergency Room for Dental Problems

It’s become widely known that many patients in high-risk groups find themselves in the Emergency Department (ED) to seek oral health care. In 2013, ORPRN worked with OHSU’s Department of Emergency Management and the University of Washington to study this problem. Hospital records showed that among young adults, non-traumatic dental problems accounted for the second most common reason for ED discharge. The study also found that ED visits reflected a lack of access to dental care and the visit was unlikely to cure the problem. Interviews with patients who have themselves visited the ED for a non-traumatic dental problem illustrated overwhelming social, economic, and behavioral barriers to receiving preventive and definitive treatment. The solutions for better oral health care access are multilevel, including such recommendations as better community education, working with schools to refer children in need of further care, and using statewide systems to address high-risk populations. As we think about oral health integration with primary care, this study supports the notion that a multidisciplinary team, including not only primary care physicians, but also schools, community programs, patient educators, and even patients themselves, will likely be necessary to improve this problem.
Integrating Behavioral Health and Primary Care in Oregon: Practice-based efforts to improve whole person care

by Elizabeth Needham Waddell, Ph.D

An Oregon Health Authority (OHA) 2015-2018 Behavioral Health Strategic Plan goal is to “target and treat common chronic health conditions faced by people with severe and persistent mental illness (SPMI), substance use disorders and co-occurring disorders.” This population has increased health risks from chronic conditions (e.g. diabetes, heart disease) associated with health behaviors (e.g. smoking, alcohol consumption, poor nutrition) and side effects from medications (e.g. weight gain, dyslipidemia, insulin resistance). But providing preventive and primary care services to patients with SPMI conditions is especially challenging when the community health center or addictions treatment is the default medical home.

Integration of Primary Care into Behavioral Health
To provide whole person care to this population, OHA and ORPRN are working on a two year project with behavioral health agencies to increase access to integrated physical and behavioral health care in Patient-Centered Primary Care Homes. The Behavioral Health Home Learning Collaborative (BHH LC) brings together behavioral health providers and primary care clinicians that have already begun integrating primary care into their adult programs. Supported by OHA’s Adult Quality Medicaid Grant from CMS, the BHH LC is part of a larger effort in Oregon to increase the number of Medicaid recipients enrolled in medical homes. Our learning collaborative provides support and technical assistance in four core areas of integrated care: 1) Screening/referral for needed physical health prevention; 2) Registry/tracking system for physical health needs/outcomes; 3) Care management; and 4) Prevention and wellness support services.

During the BHH LC, a total of 13 participating agencies will receive intensive practice facilitation, with up to two visits per month from ORPRN PERCs Molly Hamlin, Mark Remiker, and Beth Sommers. Using practice improvement approaches and methods, PERCs help the agencies identify barriers to integration and work to address them. Through the learning collaborative, participating organizations can share experiences with peers in similar organizations and receive specialized training in critical components of the behavioral health home model. Each organization will be offered scholarships to specialized training, such as Care Management Plus and Trauma Informed Care.

Integration of Behavioral Health into Primary Care
But what about integrated care for individuals with less serious needs for mental health services, such as mild depression, anxiety, or assistance for behavior modification to support control of chronic conditions? ORPRN continues to work with practices locally and across the country to support transformation efforts that bring behavioral health care into the primary care clinic. These include the InteGREAT Project, and our leadership of the Comprehensive Primary Care Initiative’s Behavioral Health Integration Action Group.

InteGREAT, or the Columbia Gorge CCO Integrated Behavioral Health and Primary Care Project, is a collaboration with the Columbia Gorge Health Council, PacificSource CCO, four primary care practices, and one community mental health center located in the Gorge. The project is designed to develop the capacity to integrate behavioral health and primary care and to share successes among the practices, spreading lessons learned to practices across the region. ORPRN PERC Beth Sommers works with participants to assess and strengthen three foundational areas of integrated care: clinical quality, operational workflows, and financial stability.

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Thank you to our BHH LC Participants:

Benton County Community Health Centers, Corvallis
Bridgeway Recovery Services, Salem
Cascadia Behavioral Healthcare, Portland
Center for Family Development, Eugene
La Clinica Health Care, Medford
Community Health Alliance, Roseburg
Community Health Centers of Lane County, Eugene
Eastern Oregon Alcoholism Foundation, Pendleton
LifeWorks Northwest, Portland & Hillsboro
Mid-Columbia Center for Living, The Dalles/Hood River
Old Town Recovery Center, Portland
Options for Southern Oregon, Grants Pass
Willamette Family, Inc., Eugene

Thank you to our InteGREAT Participants:

Columbia Crest Family Medicine, The Dalles
Columbia Gorge Family Medicine, Hood River
Columbia Hills Family Medicine, The Dalles
One Community Health, The Dalles/Hood River
Mid-Columbia Center for Living, The Dalles/Hood River
“Helping good ideas travel faster” is the motto of the Oregon Health Authority’s Transformation Center. As the state’s hub for health system innovation and improvement, the center is connecting communities so innovation in one region can spread quickly to the rest of the state and beyond. “We are excited about the large number of innovative projects being implemented throughout Oregon as part of the state’s health system transformation,” said Chris DeMars, Director of Systems Innovation. Two projects emphasize use of technology in rural communities.

Teledermatology in Yamhill County
Another way the Transformation Center supports clinical redesign is through its Clinical Innovation Fellows program. Dr. Jim Rickards, one of 13 fellows implementing local innovation projects, is using telemedicine to increase dermatology access in Yamhill County – a region with only one practicing dermatologist for more than 100,000 people.

Rickards has contracted with Dermio, a teledermatology provider, and recently launched the program at Physician’s Medical Center in McMinnville. Three more clinics will join the initial phase.

The program works like this: when primary care providers need a dermatology consult, they order it like they would an X-ray. The radiology technician in the clinic, the “super user” in this model, uses a mobile device to send a picture of the skin condition to Dermio. A dermatologist then replies with a treatment plan. Because of widespread adoption of smart devices, Rickards says the “time is ripe” for capacity-boosting telemedicine projects like this one.

Project ECHO
Health Share of Oregon, one of the state’s 16 coordinated care organizations, is using Transformation Fund grant dollars received from the Oregon Legislature in 2013 to pilot Project ECHO (Extension for Community Healthcare Outcomes) through the OHSU Telemedicine Network. Developed by the University of New Mexico, Project ECHO is an evidence-based telementoring program that uses videoconferencing to connect primary care providers with specialty providers.

The Health Share/OHSU pilot focuses on psychiatric medication management. Launched in September 2014, about 15 primary care providers now participate weekly. These Project ECHO sessions include lectures and case reviews with a psychiatrist, nurse practitioner and pharmacist. The goal is to increase the capacity of primary care providers to treat patients with psychiatric disorders, including those related to sleep and substance abuse.

The Transformation Center is exploring financial models for expanding Project ECHO to other areas of the state and has interviewed coastal ORPRN members to understand their needs.
Welcome New ORPRN Staff

Kelsey Branca, MPH
Columbia-Willamette PERC
Kelsey Branca joins ORPRN as a Practice Enhancement Research Coordinator serving the Willamette Valley region. She earned a Master’s degree in Public Health from the University of Pittsburgh. Prior to joining ORPRN, Kelsey coordinated research studies with older adults at the University of Pittsburgh and spent several years working with LGBT communities in behavioral health and social services settings.

Margaret Spurlock, MPH
Community Engaged Research Project Manager
Margaret serves as a project manager for ORPRN’s community-engaged research program. Prior to joining ORPRN she worked for the Center for Health Systems Effectiveness at OHSU coordinating a statewide behavioral health needs assessment in South Dakota. Previously she worked for the National Indian Child Welfare Association, a national nonprofit dedicated to improving the well-being of American Indian and Alaska Native children and families. She holds a Master of Public Health degree from Portland State University.

Elizabeth Needham Waddell, PhD
Senior Studies Director
Dr. Waddell leads multiple projects that focus on practice transformation and integration of primary and behavioral health care as ORPRN’s Senior Study Director and Assistant Professor of Public Health & Preventive Medicine. She received a PhD in Sociomedical Sciences at Columbia University and then completed a postdoctoral fellowship in NIDA’s Behavioral Sciences Training Program in Drug Abuse Research. Prior to joining ORPRN, Dr. Waddell was a Research Scientist and Unit Director at the New York City Department of Health & Mental Hygiene.

Chou Xiong
Eastern Oregon Regional PERC
Chou is the Practice Enhancement Research Coordinator serving eastern Oregon. Prior to joining ORPRN, Chou worked as a Community Engagement Representative with the Clinical and Translational Research Institute at UCSD, where she worked increase the health research literacy of community members. Chou also worked with a community-based health organization in Merced, CA to eliminate health disparities in the Hmong community.