Connecting, Involvement, Community Health

ORPRN
Oregon Rural Practice-Based Research Network

The Walls Fall Down
Linkages between Primary Care Practice and Community Resources

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

This year’s ORPRN Convocation, Addressing Health Disparities in Primary Care, represents an evolution of primary care practice observed during ORPRN’s 14-year history. When ORPRN was founded in 2002, primary care in rural Oregon was predominantly delivered by small, independently owned practices. The typical structure of the practice was a 2 - 4 physician/medical assistant dyad that was located in each corner of the office building. In many cases these dyads spent much of the day working in isolation, each seeing, referring and managing 20 to 30 patients. The dyads functioned to increase the number of patients the physician was seeing, and there was little impetus or support to test new models of care. In 2006, forty percent of ORPRN practices were using an electronic health record and the critical access hospitals care records were paper-based.

Over the next decade, the complexity of patient care, emphasis on the meaningful use of electronic health records and a changing payment system challenged the traditional practice model. In response the creation of the patient-centered primary care home and coordinated care organization models pushed primary care practices to transform beyond the core physician/medical assistant dyad. Team-based care became increasingly important as the transformation began to move care beyond the walls of the practice to improve population health.

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As practices are transforming, so is the focus of ORPRN projects. A number of ORPRN studies required practice change that is disruptive and involves dissemination and implementation of best models of care. These projects include behavioral health integration, care coordination, optimal use of health information technology, shared decision making, quality improvement, (Continued on Page 3)

What drives quality improvement? A robust road map:
Healthy Hearts Northwest's Key Driver Diagram

by Caitlin Dickinson, MPH, ORPRN Project Manager and Beth Sommers, MPH, ORPRN Practice Enhancement Research Coordinator

“A good plan is like a road map: It shows the final destination and usually the best way to get there.”
– H. Stanley Judd

Are practices ready for quality improvement?

In last year’s ORPRN Spring Newsletter, ORPRN Director Dr. LJ Fagnan asked our primary care community: “Are you ready?” Are practices ready for future reimbursement that will be based on the ability to use data for improvement? Are practices ready to collect and utilize quality metrics to improve population-based health as a core competency? Are practices ready to adopt a strong quality improvement (QI) infrastructure? Over the past year, we have detected Oregon practices’ readiness to address QI!

While many practices have indicated a need to focus on QI, most still struggle to truly implement a QI infrastructure. As stated by Taylor et al, “Despite the promise of QI capacity to help improve primary care delivery, the financing and structure of primary care in the United States makes it difficult for primary care practices to build QI capacity on their own. Most primary care practices do not have the time, resources, or expertise needed to focus on practice improvement.” As our (Continued on Page 2)
(Cont. from Page 1) healthcare environment continues to evolve rapidly, practices face challenges around the ability to effectively use data to improve quality. Many practices, especially smaller ones, lack the internal resources for optimizing health information technology (HIT) and building QI capacity.

Yes: Strong support for H2N.
In an effort to address the current QI challenges confronting primary care practices, ORPRN has enthusiastically launched a new project titled Healthy Hearts Northwest (H2N). H2N is part of a three-year national initiative called EvidenceNOW, funded by the Agency for Healthcare Research & Quality, aimed at improving cardiovascular health across the United States. Cardiovascular disease is the leading cause of death for both men and women in the United States, accounting for 1 in every 4 deaths. Designed for small- to medium-sized primary care practices, H2N is an opportunity to build QI infrastructure while working towards better heart health outcomes for patients. Each enrolled practice works with a Practice Enhancement Research Coordinator (PERC) to tailor the program for their specific needs, and receives 15 months of structured support. PERCs help practices identify areas for improvement, and introduce practices to new ideas, tools, and methods while guiding them to integrate a comprehensive QI structure into the existing framework of their medical practice.

As of this writing, 94 Oregon primary care practices have enrolled in H2N, and we anticipate working with an additional 40 practices by May 2016. While our enrolled practices are excited to focus on the clinical components of the project, many are particularly interested in the incorporated QI elements of it. When asked reasons for engaging in H2N, practices’ responses primarily fell into one of three categories:

1. To find an organized way to understand QI processes and develop a QI framework.
2. To learn how to leverage EMRs to be more efficient in: tracking patients, streaming data pulls, coding for services, and billing.
3. To improve patient outcomes.

The H2N Road Map.
As stated by Nicole Van Borkulo, Project Director of the H2N Practice Coaches Learning Community, “In any change initiative, it is critical to be clear about where you are going.” An essential element of H2N is providing practices with a ‘road map’ for building their capacity and for doing quality improvement well. We call this road map for our ‘Key Driver Diagram’.

The Key Driver Diagram is based on the learnings of several other initiatives, but is primarily based on the framework created for the Safety Net Medical Home Initiative (SNMHI). It outlines the main activities that PERCs will support practices in implementing over the course of the 15 month project. The Diagram outlines the continuum of theory (Change Concepts), goals (High Leverage Changes), and actionable items (Key Activities) that will affect and/or impact the outcomes practices intend to achieve for H2N: improvement in the ABCS quality metrics and increased QI capacity and capability. While the High Leverage Changes (HLCs) are elements that have been studied through the SNMHI and shown to be integral to practice transformation and sustainable QI work, the Key Activities represent actionable steps practices can take to achieve the HLCs, and are the main focus of the PERCs’ work with practices.

“...This is an excellent opportunity to improve health outcomes for our county.”

This project gives us a “jumpstart” and “re-boosts our energy.”

Since H2N’s project launch in Fall 2015, we have received several powerful messages from engaged providers and clinic staff, including:

- “This is an excellent opportunity to improve health outcomes for our county.”
- This project gives us a “jumpstart” and “re-boosts our energy.”
- “In the past we provided data that wasn’t particularly useful or actionable. We’d say ‘Okay, here’s your no-show rates, and it looks like you’re not seeing very many people.’ It didn’t have a lot of meaning for the providers. We are hoping to change that (through this project).”

Thanks to our Key Driver Diagram, H2N is aptly designed to support practices in collecting and utilizing quality metrics to improve population-based health. We look forward to supporting practices in learning how to build robust QI programs, and we are excited and honored to be their partner on this journey!

*Erin Fries Taylor, et al. Building Quality Improvement Capacity in Primary Care. AHRQ Pub # 13-0044-2-EF*
(Cont. from Page 1) and population health. Our project implementers, the ORPRN Practice Enhancement Research Coordinators (PERCs), have been identified by practices as a key transformation asset beyond just an individual study. Our largest project, Healthy Hearts Northwest, is built on the PERC foundation of practice facilitation. To facilitate improvements in the Million Hearts metrics, ORPRN has ten PERCs connecting with over 100 primary care practices across the state. The PERCs foster a continuity relationship with their cohort of practices, working in partnership to develop a high-functioning quality improvement infrastructure and use of team-based care to improve the cardiovascular health of their patient population. Implementing this effectively calls for robust linkages to evidence-based community resources.

When establishing relationships with community resources, the PERC functions as a health extension agent. The health extension model is built on the agricultural extension service approach developed in Oregon in 1911, where Oregon Agricultural Faculty brought research-based knowledge to communities around the state to improve farming practices. The ORPRN PERC model started in 2003, bringing innovation and evidence-based practice knowledge to practices throughout the state to improve the quality and safety of care. As health extension agents, PERCs help communities and the primary care practices that serve them overcome barriers to transformation by sharing common resources. ORPRN practices are a source of new knowledge as well and the PERCs promote the attributes of the network by sharing best-practices from one community to another.

Health extension may be especially effective in reducing social disparities in health (i.e. health differences by socioeconomic factors such as income and education). Addressing health disparities requires strong and functional linkages between primary care practices and community resources. The 2016 ORPRN Convocation brings in a valuable resource, the Community Health Worker (CHW), to promote a model of connecting those experiencing health differences to community resources and primary care practices. The CHWs are frontline workers who are trusted members of the communities they serve. They can improve access to care through outreach and by building the cultural and community competence of care teams and organizations. The ORPRN PERC, as a trusted practice ally, has an opportunity to collaborate with CHWs to stimulate these linkages to improve community health. Integration of CHWs into practice care teams and deployment into communities is a key strategy for transforming primary care. One of ORPRN objectives over the next two years is to study and implement optimal models of integration to address social disparities in health.

ORPRN has ten PERCs connecting with over 100 primary care practices across the state.

Recent ORPRN Publications


For full list of ORPRN Publications and links to the articles visit www.ohsu.edu/orprn
Ron, a burly long time musician, is a patient at Central City Concern’s Old Town Recovery Center in downtown Portland. He tells his story in the office of his counselor, Kelly Fitzpatrick: “Twenty-nine months ago, I set out on a quest to end my life. I was dealing with uncontrollable moods. I sold all my guitars, all my belongings.”

Ron is recovering from heroin addiction and alcoholism. He also lives with bipolar disorder and PTSD. “But now,” he says, “I can say that the last five months have been the best of my last 15 years. I'm comfortable in my own skin. I’m happy.” He’s both emotionally stronger and in better physical health. Over the last year, he has lost 40 pounds and his blood sugar, once at pre-diabetes levels, has dropped sharply. He ascribes his dramatic improvement to the “great communication between Kelly, my doctor, and my nurse practitioner.”

Ron is one of 200 patients in Central City Concern’s one year-old IHART program. Mental health specialists, addictions counselors, peer wellness counselors and case managers work closely with primary care practitioners to provide wraparound treatment for patients’ mental and physical health. The program is funded by a federal grant that CCC received in September 2014, with the purpose of developing a health home model for patients with co-occurring severe mental illness and complex medical needs, blending evidence-based models of care from both primary care and mental health.

IHART is participating in ORPRN’s Behavioral Health Home Learning Collaborative (BHHLC), and the early success of the program is a positive indicator for the Collaborative, which is gathering data to promote the integration of primary care in a behavioral health setting. CCC’s Old Town Recovery Center is one of nine mental health and substance use disorder treatment programs from Oregon participating in the Collaborative.

All IHART patients, according to team manager Shanako DeVoll, come to the program after being assessed at the Old Town Clinic, a federally recognized patient-centered medical home serving people experiencing homelessness and poverty. People placed in the IHART program are dealing with severe mental illness and addictions as well as medical issues. They also need wraparound care to help them achieve basic needs.

“People with a major mental illness who receive publicly funded health treatment, die, on average, twenty-five years earlier than people in the general population. That's unacceptable. We have to do something.”

Sixty-eight percent of people with a mental illness have one or more chronic physical conditions often related to their psychiatric medications or conditions - these include obesity, high blood pressure and high blood sugar. If not monitored closely, these can lead to heart disease, type 2 diabetes and early death.

“People with a major mental illness who receive publicly funded health treatment, die, on average, twenty-five years earlier than people in the general population. That's unacceptable. We have to do something,” CCC’s Psychiatric Medical Director, John Bischof.

The IHART program aims eventually to be the patient’s primary point of contact for psychiatric and metabolic medical concerns and to reduce the prevalence and impact of metabolic conditions among patients.

Central City Concern’s leadership are encouraged by such early successes and are evaluating bringing IHART attributes into other programming at the agency. “We’re excited to keep developing this model,” says Tallyn. “It’s bringing together the best of primary care and mental health models, and the potential to improve patients’ lives—and our care system—is huge.”

Want more results from the BHHLC? Contact PI, Elizabeth Needham Waddell, PhD waddelle@ohsu.edu
Northwest Primary Care
LTC Hotline and Community Resource Projects
by Daniel Wilkes, Care Coordination Director at Northwest Primary Care Sellwood/Westmoreland Clinic

LTC Hotline
Northwest Primary Care (NWPC) is a group of family and internal medicine clinics in Portland, Oregon participating in the Comprehensive Primary Care initiative; a national study of primary care transformation facilitated by ORPRN PERC Ann Romer. While reviewing a report of Emergency Department (ED) visits by NWPC patients provided by a nearby hospital, the Care Coordination Team Leader, Kate Dowd Esser, discovered that many of the ED visits could have been treated at a primary care level. Additionally, many of the patients listed on the report were residents of long-term care (LTC) facilities (i.e. assisted living, residential care, intermediate care, adult foster care, independent retirement, and memory care).

To improve patient care for those residing in LTC facilities, NWPC established a LTC hotline to provide direct access for LTC staff to NWPC's clinical staff. This team is trained in responding to common questions such as medication orders, changes in status reports, requests for home health or hospice, transitions of care, and illness outbreaks.

The NWPC team believes that if it provides LTC staff members with a direct conduit to the services provided by a resident's PCP, it will be a step toward the goal of reducing ED visits. During this process LTC residency is also tracked, which the NWPC team anticipates will give them a chance to pinpoint recurring issues, such as a higher number of ED visits from a particular facility that could have been redirected. This will provide an opportunity to educate those particular facilities.

To facilitate implementation of the program, NWPC’s Communications Director, Trudy Suski, developed special promotional materials (posters and magnets) as well as an outreach program to boost awareness among providers, patients, and LTC facilities. The patient posters will be placed in a prominent location in each LTC resident's room so the family and facility caregivers will have easy access to the name and contact information of the patient's PCP.

Community Resource Guide
NWPC also developed an internal web-based community resource guide called the Community Resource Intranet Project (CRIP). The concept is modeled after the popular Street Roots resource guide available in Multnomah and Washington counties and the 211-service directory accessible throughout Oregon.

The NWPC Care Coordination team identified a need internally for a simplified, up-to-date service guide with practice-wide accessibility and applicable to the needs of NWPC patients, which would include resources serving Clackamas County (where four of NWPC's five clinics are located). The directory - just a click away for all staff and providers - lists services in Multnomah and Clackamas counties by service category. Categories in CRIP include transportation services, transitional housing, food and grocery assistance, and many more. The CRIP lists the resource's phone number, web address, physical address, and a brief description of the service. The CRIP is printable and searchable, which instantly allows for providers, nursing staff, support staff, and the Care Coordination team to identify services applicable to a patient's needs, and hand them to the patient. The list will be updated as the staff learns about new resources. The team will curate the content at regular intervals to ensure accuracy and relevance.

Currently the CRIP is active only for internal NWPC staff, but the group is exploring the possibility of making it publicly available on the NWPC website once the project moves beyond its pilot phase.

Interested in learning more? Visit www.nwpc.com
What is a Community Health Worker?

Community health workers connect underserved individuals to primary care, social services, and basic health education, and can provide informal counseling, advocacy, system navigation, care coordination, and social support. A unique characteristic of community health workers is that they are trusted members of the community and are generally linked to the communities they serve by culture, language, and socioeconomics\(^1\). There is no single job description for a community health worker. They are both paid and volunteer, and come from non-medical and medical backgrounds.

Professional standards for community health worker education, credentialing, and payment structure differ by state\(^2\). As of October 2015, the Oregon Health Authority (OHA) has certified over 700 “traditional health workers,” including community health workers, peer support specialists, peer wellness specialists, peer health navigators, and birth doulas\(^3-4\). The Traditional Health Worker Commission advises and provides recommendations to the OHA to ensure the program meets community and consumer needs\(^5\). Some services provided by certified traditional health workers are reimbursable through the Oregon Health Plan. In addition, a number of coordinated care organizations have used Transformation grants to fund traditional health worker programs in their regions\(^6\).

About ConneXions

ConneXions is a community health worker program led by Good Shepherd Medical Center that closely partners with Umatilla County Human Services and Lifeways (behavioral health services provider for Umatilla and Malheur counties)\(^7-8\). Current staffing includes five community health workers (including two who are bilingual in Spanish and English) and one part-time nurse. The program aims to both reduce avoidable emergency department visits among “high utilizers” and to reduce hospital readmissions by connecting Umatilla and Morrow county residents to primary and specialty medical care, behavioral/mental health, substance abuse services, general social services, and resources for basic needs such as housing, transportation, food, and interpretation/translation.

Referrals come from Emergency Department Information Exchange (EDIE) alerts; the Good Shepherd Medical Center emergency department; hospital case managers; primary care providers; community agencies; and word of mouth. Weekly multi-disciplinary team meetings with community partners support care coordination and keep patients at the center of care.

Initially funded by grants from the Eastern Oregon Care Coordination Organization (EOCCO) and Medicare, ConneXions grew from the Healthy Communities Coalition, a multi-stakeholder group that includes the Oregon Department of Transportation, Fire/EMS, Head Start, Department of Human Services, law enforcement, public health, and area schools\(^9\). Since November 2014, ConneXions has served over 1,300 community members in Umatilla and Morrow counties.

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1. “Promotores de Salud/Lay Health Worker Model” www.ruralhealthinfo.org/community-health/community-health-workers/2/layhealth
8. “Lifeways website” www.lifeways.org
Connecting Community Members and Primary Care Providers with Resources: An Interview with Juli Gregory, RN, Education Director and Director of ConneXions at Good Shepherd Medical Center

by Maggie McLain McDonnell, MPH, Project Manager, ORPRN

Maggie McLain McDonnell, MPH, Project Manager, ORPRN, interviewed Juli Gregory, RN, Education Director and Director of ConneXions at Good Shepherd Medical Center to learn more about how community health workers and primary care providers can work together to improve the health of their patients.

**How can the services that community health workers deliver enhance the services provided by primary care practices?**

Juli Gregory: In addition to clinic referrals to community health workers (CHWs), CHWs can attend primary care appointments with patients to provide “two pairs of ears” to hear provider instructions. After the provider visit, the CHW is able to verify the patient’s understanding of the provider instructions, help the patient follow through on provider instructions, connect patients to other resources that may be identified during an appointment, and start an education plan and care plan. We have found that the providers love it. While it can be time consuming and takes coordination, it is especially helpful for CHWs to attend provider appointments with patients who have lower health literacy, reduced memory function, or medication adherence concerns.

In situations where interactions between CHWs and primary care providers have been the most successful, providers have been welcoming and communicate with both the patient and community health worker to ensure the community health worker is part of the healthcare team and care planning team. CHWs can also create an education plan to help patients to “take the elephant one bite at a time,” so that information is thoroughly understood before adding another piece.

**Do you have any advice for primary care practices looking to start a community health worker program within their practice, or to engage with existing community health worker initiatives in their communities?**

Juli Gregory: For those looking to start a CHW program in their clinic, it’s ideal to hire a CHW with a medical background (such as certified medical assistant), and a behavioral health background or someone with strong connections to mental health resources in the community. It’s also crucial to make sure that their role is clearly defined, so that they don’t get pulled into doing other tasks, such as cleaning exam rooms or answering phones. Under the provider’s supervision, they could help with medication adherence and also provide home assessments. Some patients will not always tell providers what is going on at home.

"It needs to be part of a provider’s everyday thought process to think about a patient’s possible social and health education needs."

A home assessment can provide a better picture. Practices can also build relationships with local emergency departments and utilize the Emergency Department Information Exchange (EDIE) reports. Ideally CHWs will follow up with patients admitted to the emergency department in real time rather than waiting a day or two. It’s recommended that CHWs participate in area multi-disciplinary team (MDT) meetings. The networking and resource sharing that occurs during MDT meetings is very valuable to learn about local resources and share approaches. Lastly, warm hand offs from either the medical assistant or provider to the CHW is critical to help everyone work together as a team to create a care plan and education plan while keeping the patient at the center of their care.

To engage with existing programs, invite a program representative to talk to your providers and staff to understand what CHWs can and cannot do. Be aware that these programs are there, and then access them. Don’t be afraid to refer. It needs to be part of a provider’s everyday thought process to think about a patient’s possible social and health education needs. Also have a release of information in place to have conversations, keep patients in the center, and allow building of trust between organizations. As you work together more, more trust is built.

**This interview has been condensed and edited.**
**Welcome New ORPRN Staff**

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<tr>
<th>Name</th>
<th>Role/Position</th>
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<tbody>
<tr>
<td>Bruce Goldberg, MD</td>
<td>Senior Associate Medical Director</td>
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<tr>
<td>Tracy Anastas</td>
<td>Senior Research Assistant</td>
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<tr>
<td>Steven Brantley, MPH</td>
<td>Southern Oregon Practice Enhancement Coordinator (PERC)</td>
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<tr>
<td>Kristin Chatfield, MPP</td>
<td>Cascades East Practice Enhancement Coordinator (PERC)</td>
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<td>Emily Chirnside</td>
<td>Portland-Metro and Columbia Gorge Practice Enhancement Coordinator (PERC)</td>
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<td>Angela Combe, MS</td>
<td>Eastern Oregon Practice Enhancement Coordinator (PERC)</td>
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<tr>
<td>Cullen Conway, MPH</td>
<td>Northern Willamette Valley Practice Enhancement Coordinator (PERC)</td>
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<tr>
<td>Anne King, MBA</td>
<td>Director of Health Care Initiatives</td>
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<tr>
<td>Caitlin Dickinson, MPH</td>
<td>Healthy Hearts Northwest Project Manager</td>
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<tr>
<td>Alisa Jackson</td>
<td>Administrative Coordinator</td>
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<tr>
<td>Maggie McLain McDonnell, MPH</td>
<td>Project Manager</td>
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<tr>
<td>Katrina Murphy</td>
<td>Research Assistant</td>
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<tr>
<td>Todd Noletto, MPH</td>
<td>Southern Willamette Valley Practice Enhancement Research Coordinator (PERC)</td>
</tr>
<tr>
<td>Robyn Pham</td>
<td>Community-engaged Research Project Manager</td>
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**Contact us**

Website: [www.ohsu.edu/orprn](http://www.ohsu.edu/orprn)

Phone: (503) 494-0361

Email: orprn@ohsu.edu