ORPRN STUDIES: How we’re affecting healthcare

A snapshot of ORPRN studies in 2018
Presentation of ORPRN studies

• Nine projects in one hour
• Presentations will follow a similar format
  – What critical question does this project answer?
  – How this study can impact healthcare
• Studies will be clustered to most related pillar
• Many studies are recruiting practices for participation now
ORPRN’s Four Pillars

Collaborative Community Health: Outreach, Research, Health Transformation, Education Planning Document

Community Engagement: Building Motivation and Increasing Capacity
Practice Transformation: Connecting Practices and Delivering Services
Research: Research is a Community Asset
Education: Knowledge is Power

ORPRN STATEWIDE STEERING COMMITTEE
ORPRN Pillar #1: RESEARCH

- Generate new knowledge to help set standard of care
  - Clinical trial
  - Comparative effectiveness
  - Validation of screener
Meta-LARC ACP

Promoting healthcare that supports what is important to people with serious illnesses

A cluster-randomized controlled trial comparing primary care clinician-focused versus team-based implementation of advanced care planning

Funding: PCORI 4 years: 11/15/17 - 12/14/21

Annette Totten, PhD
Advance Care Planning for People with Serious Illnesses

18+, Healthy
- Identify Health Care Proxy (HCP)
- Conversation about care preferences

Diagnosis of Serious or Chronic Illness(es)

Progression of Serious or Chronic Illness(es)
- Have Serious Illness Conversation

Condition worsening
- Revisit Serious Illness Conversation
- Goals of Care Discussion (if clinical decision)

Poor Prognosis
- Revisit Serious Illness Conversation / Goals of Care Discussion
- MOLST / POLST

Seriously Ill

Crises & Decline

End of Life

Prognosis: Weeks to Months

Prognosis: 1-2 Years
We all have a story...

Eileen Speer.
Not happy I went to France and
left her with 2 cats and 2 men

Really Bad Red Wine.
(probably Lake Niagara)

Hal Speer
Photographer, Time/Life
Circulation Manager, Motorcycle
Advocate, Polio Survivor

-August 1999 Cancer Dx
Radiation/Feeding Tube
(no discussion of Palliative Care)

-September 1999 fell at home,
ruptured incision, “guts fell out”

-February 2000 in died in a State
Veterans Home without his cat or
a scotch

Wrex.
The cat I left with Hal when
I went to France and never
got back. Hal cooked for
him and taught him to tell
time.
Serious Illness Care Program

- Ariadne Labs
- www.ariadnelabs.org
Models

Serious Illness Care Program

Clinician Focused

Identify + Select ➔ Invite ➔ Document ➔ Goal Concordant Care Time at Home

Setup Assess Share Explore Summarize Recommend Follow-up

Revise Revisit

Team Based

Identify + Select ➔ Invite ➔ Document ➔ Goal Concordant Care Time at Home

Setup Assess Share Explore Summarize Recommend Follow-up

Revise Revisit
Study organizational chart
Meta-LARC ACP
Stakeholder Engagement Structure

- PBRN Operations
- PFACs
- National Patient & Family Networks
- External Stakeholder Partners

Color Key: dark blue = patients; light blue = families; orange = primary care clinicians; green and purple = primary care staff and administrators; yellow = external stakeholders; red = researchers (investigators and staff)

*Figures represent types of participants, not the number of members.*
Stay tuned

• Project email: METALARC_ACP@OHSU.edu
• Break-out session today
• Updates
  – ORPRN news
  – See you next year
A New Approach to CAPTURE™ COPD*  
An NHLBI-funded study

Funding Agency: National Heart, Lung, and Blood Institute (NHLBI)  
Project Dates: 9/1/17-6/30/22  
Project Manager: Caitlin Dickinson
What critical question does this project answer?

Study Goal: *Validating a unique COPD screening tool to identify undiagnosed COPD patients*

- Leading cause of morbidity and fourth leading cause of death in U.S.
  - 10% of Oregonians 65+ years old live with COPD

- Reliance on and inconsistent use of spirometry
  - Impaired health status, acute respiratory deteriorations, increased mortality, and increased health care utilization
Who are our project partners?

<table>
<thead>
<tr>
<th>Partner</th>
<th>Project role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weill Cornell</td>
<td>Investigator</td>
</tr>
<tr>
<td>University of Michigan</td>
<td>Investigator, project leads, data coordinating center</td>
</tr>
<tr>
<td>University of Minnesota &amp; National Jewish Health</td>
<td>Project leads</td>
</tr>
<tr>
<td>NHLBI</td>
<td>Overall project support</td>
</tr>
</tbody>
</table>
ORPRN will enroll 1000 patients from ~20 clinics (50 patients/clinic) in Oregon

- Target population: Patients between the ages of 45-80 years old with no prior COPD diagnosis.
Clinic Responsibilities & Study Components

Clinic Responsibilities
• Each clinic will support the coordination of patient recruitment and clinic space over the course of a month.
• Clinics participate in a 1 hour COPD educational session with lunch provided.
• Clinics are NOT responsible for patient recruitment and study procedures.

Study Components
• Patients will be notified about the study opportunity via postcards prior to their primary care appointment.
• Interested patients will be asked to arrive 1.5 hours before their appointment.
• Patients will complete a consent form, questionnaires, a PEF test, and a spirometry test.
• Patients may be contacted 12 months later to complete a follow-up assessment.

Clinics will contribute to advancing national research knowledge of early detection of COPD.
How can this study impact healthcare?

Our principal hypothesis is that CAPTURE will identify subjects with previously undiagnosed, clinically significant COPD in primary care. We further hypothesize that CAPTURE can be integrated into a wide variety of primary care clinical settings, prove effective in improving the diagnosis and follow-up of COPD related care, and improve clinical outcomes.
Next Steps

• Finalize protocol
• Submit IRB documents
• Train coordinators
• Enroll practices
• Train clinic staff
• Enroll patients!!!

CAPTURE™ COPD

COPD ASSESSMENT IN PRIMARY CARE TO IDENTIFY UNDIAGNOSED RESPIRATORY DISEASE AND EXACERBATION RISK

A New Approach to CAPTURE™ COPD

COPD: Chronic obstructive pulmonary disease

3rd leading cause of death in the U.S.

Earlier detection of COPD might help primary care physicians offer treatment to improve patient condition.

- More than 10% of Oregonians 65 years and older live with COPD.*
- Early diagnosis is essential to manage symptoms.
- COPD is underdiagnosed in part due to reliance and inconsistent use of spirometry.
- An NHLBI-funded study. CAPTURE involves a brief screening questionnaire to help detect COPD earlier in patients with unrecognized symptoms.

Your practice is eligible to participate in the CAPTURE Study

Benefits of Participation:
- Practices will get $25/patient enrolled (~$1250/practice)
- Research staff will enroll patients on site (~60 patients/practice)
- Patients will be compensated up to $95 for their time
- Recruitment will last approximately 1 month
- Practices will receive a COPD educational session with lunch provided
- Practices will contribute to advancing national research knowledge of early detection of COPD

Are you interested in participating?
- Very interested, please plan to include our practice!
- Interested, but we need more details before we could commit.
- Not interested.

If interested, please provide:
Your name
Your clinic:

For More Information Contact:
- Research Coordinator: Martha Snow – snowm@ohsu.edu, 503-494-1510
- Project Manager: Caitlin Dickinson – caitlin@ohsu.edu, 503-494-9196
- Principal Investigator: LJ Fagmam – fagman@ohsu.edu, 503-494-1682

*CDC Chronic Obstructive Pulmonary Disease: COPD Among Adults in Oregon. https://www.cdc.gov/copd/resources/docs/CAPTURE_COPDFactSheet.pdf

ORPRN Oregon Rural Practice-Based Research Network
MAPPN Oregon Health Authority Research Network
PCRC Oregon Patient-Centered Research Network

HIGHPLAINS RESEARCH NETWORK COPD mAPPN PCRC OHSU

CAPTURE™ COPD OHSU Oregon Health & Science University

©2022 Oregon Rural Practice-Based Research Network
Please contact us if your practice is interested in participating!

Caitlin Dickinson, summerca@ohsu.edu, 503-494-9106
CASCADE: A Community-based Assessment of Skin Care, Asthma, and Eczema

**Funding Agency:** National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS)

**Project Dates:** 2018 - 2022

Kelsey Branca, MPH, CCRP
What critical question does CASCADE answer?

Primary Objective:
• Can daily emollient therapy beginning in the first 2 months of life reduce the cumulative incidence of atopic dermatitis at 24 months of age in a community-based, average-risk setting?

Secondary Objectives:
• To determine whether an atopic family history and key early life exposures modify the effect of emollient therapy on atopic dermatitis.

• To assess the effectiveness of emollient therapy on the development of reported allergic comorbidity symptoms such as food allergy and wheeze episodes.
# Project partners and expertise

<table>
<thead>
<tr>
<th>Partner</th>
<th>Role</th>
</tr>
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<tbody>
<tr>
<td>OHSU Dermatology</td>
<td>PI Eric Simpson, clinician and researcher focused on atopic dermatitis</td>
</tr>
<tr>
<td>Meta-network Learning And Research Center (Meta-LARC)</td>
<td>Co-I L.J. Fagnan leads PBRN consortium, in Oregon, Wisconsin, Colorado, North Carolina</td>
</tr>
<tr>
<td>OHSU Data Coordinating Center</td>
<td>Co-I Cynthia Morris, epidemiologist leads team to build study database, CRFs, MOOP</td>
</tr>
<tr>
<td>OHSU School of Public Health</td>
<td>Co-I Jodi Lapidus, statistician implements Statistical Analysis Plan</td>
</tr>
<tr>
<td>University of Utah Trial Innovation Network (TIN)</td>
<td>Provides central institutional review board (IRB) oversight</td>
</tr>
<tr>
<td>KAI</td>
<td>Liaison to NIAMS and DSMB</td>
</tr>
<tr>
<td>Data Safety Monitoring Board (DSMB)</td>
<td>Board providing patient safety oversight</td>
</tr>
</tbody>
</table>
Map of setting

Goal: Recruit 1,250 parent-infant pairs over two years at 25 primary care clinics

- ORPRN: 10 clinics
- WREN: 5 clinics
- SNOCAP: 5 clinics
- Duke PCRC: 5 clinics
How this study can impact healthcare:

The CASCADE study could change the standard of skin care for infants world wide.

Why do we care about preventing atopic dermatitis/eczema?

• AD the most common chronic disease of childhood
• Affects up to 18% of children in U.S.
• Causes most disability of any skin disease globally
  – Emotional and behavioral, sleep loss, family impact > DM, increased risk of ADHD
Design and methods

• **Design**: Pragmatic, multi-site, randomized community-based trial
  – Arm A: Daily use of lipid-rich emollient
  – Arm B: Routine skin care

• **Target population**: Pairs of one parent/guardian and one infant >8 weeks old who receive care at one of 25 PBRN-affiliated primary care clinics

• **Eligibility Criteria**: Parents of infants must:
  – Be a primary caretaker of infant aged 0-2 months
  – Be aged 18 years or older
  – Speak, read and write in English / Spanish
  – Have valid e-mail address and reliable internet
  – Receive care at Meta-LARC clinic at enrollment

• **Outcome of interest**: Cumulative incidence of atopic dermatitis (AD, eczema) when infant/baby is 24 months old
What did we learn?

CASCADE U34 Planning Grant, 2015-2016

Table 1: Atopic dermatitis prevalence, severity, and medication prescribed, by age

<table>
<thead>
<tr>
<th>Age</th>
<th>N</th>
<th>Prevalence of AD (a)</th>
<th>N</th>
<th>Moderate/severe rash (b)</th>
<th>Sleep disturbed in past week (c)</th>
<th>Medication prescribed (c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>652</td>
<td>24 (21-28)</td>
<td>159</td>
<td>42 (36-47)</td>
<td>21 (15-27)</td>
<td>75 (68-82)</td>
</tr>
<tr>
<td>Child age   &lt; 1 year</td>
<td>240</td>
<td>15 (12-17)</td>
<td>35</td>
<td>48 (37-60)</td>
<td>24 (11-37)</td>
<td>67 (54-79)</td>
</tr>
<tr>
<td>1 year</td>
<td>165</td>
<td>24 (19-29)</td>
<td>39</td>
<td>29 (13-44)</td>
<td>15 (5-24)</td>
<td>69 (56-82)</td>
</tr>
<tr>
<td>2-3 Years</td>
<td>130</td>
<td>31 (22-40)</td>
<td>40</td>
<td>41 (28-53)</td>
<td>22 (6-39)</td>
<td>75 (60-90)</td>
</tr>
<tr>
<td>4-5 years</td>
<td>117</td>
<td>38 (29-48)</td>
<td>45</td>
<td>49 (31-66)</td>
<td>22 (14-31)</td>
<td>86 (76-97)</td>
</tr>
<tr>
<td>p-value(d)</td>
<td>&lt;0.001</td>
<td>.094</td>
<td>.69</td>
<td>.019</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(a\) represent every history of AD; \(b\) <3\% reported severe rash overall; \(c\) Percents are mean predictions from a logistic model with clustered standard errors to account for correlation between children from the same clinic; \(d\) P-values from likelihood ratio chi-square test. \(d\) Includes children age 6 years, 0 months.
Next steps

• PBRN Kick-Off Visits
  – Wisconsin
  – North Carolina
  – Colorado

• Clinic training
  – Still recruiting 3 primary care practices in Oregon

• Participant recruitment (June 2018)
If your practice is interested in participating in the CASCADE Study:

- Email us: cascadestudy@ohsu.edu
- Contact LeAnn Michaels, Meta-LARC Program Manager: (503) 494-1583
- Find the CASCADE Project Summary form on the ORPRN table and send back to our team.

CASCADE Project Summary

The National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) will fund an investigator-initiated research study titled Community-based Assessment of Skin Care, Allergies, and Eczema (CASCADE). This pragmatic, multi-site, randomized community-based trial prospectively investigates the prevention of atopic dermatitis (AD) in infants.

CASCADE will enroll 1,250 pairs, each consisting of a parent/legal guardian (“parent”) and an infant age 0-2 months, from 25 community-based family medicine and pediatric clinics in Colorado, Oregon, North Carolina, and Wisconsin. Each clinic will be asked to enroll two pairs per month for approximately two years, for a total of 50 pairs per clinic.

Recruitment:
- Parents of infants less than two months old will be invited to enroll when they present with their infant for a routine well-child office visit.
- Parents must be able to read and speak English or Spanish and will be given a prescreening consent form using an electronic tablet, such as an iPad (provided by the study team).
- Eligible parents will provide electronic consent. After consent, pairs will be randomized to an intervention group (daily full-body emollient on infants until age 24 months) or control group (refrain from use of emollient cream unless dry skin occurs until age 24 months).
- There are no study visits required to participate in the study. All study communication with enrolled pairs will take place through phone, email, website, and text messages.

Intervention:
- Participating parents are randomly assigned to receive either an emollient with web-based instructions for daily use for their infant plus routine skin care instruction (intervention group) or routine skin care instruction alone (control group). There is no active intervention. All emollients used in this trial are FDA-approved and available over-the-counter for purchase.
- Parents in both intervention and control groups will receive a weekly text message reminder to follow protocol instructions until the infant reaches 24 months old.
- Parents complete brief surveys quarterly via text message or email.
- Parents complete a longer survey when their child is 12 months and 24 months old.

Study sites receive the following:
- $1,000 study startup payment plus $1,000 bonus
- Electronic tablet (i.e., iPad)
- Reimbursement of $25 per pair enrolled

Participating patients receive the following:
- $160 for completing three surveys over 24 months
- Intervention group receives free 24-month supply of emollient of choice

If you are interested, please email this form to cascadestudy@ohsu.edu or fax to 503.494.1513.

Clinic name: ______________________
Your name: ______________________

ORPRN
Oregon Rural Practice-Based Research Network
ORPRN Pillars #2-3: Transformation and Engagement

- Implementing evidence into primary care practice
  - Quality improvement
  - Academic detailing
  - Peer-to-peer learning

- Involving communities in addressing relevant issues
  - Translating evidence
  - Community-identified problems
  - Building community capacity
  - Referring to community resources
Project Dates: May 1, 2015 – April 30, 2019
Funding Agency: Agency for Healthcare Research and Quality (R18HS023908)

Cullen Conway, MPH, CCRC
Healthy Hearts Northwest (H2N)

The goal of H2N was to study strategies to build QI capacity in primary care practices with a focus on improving cardiovascular risk factors

Million Hearts Measures: Aspirin, Blood Pressure, Cholesterol, Smoking Cessation (ABCS)

1. Embed clinical evidence
2. Review ABCS measures
3. Establish a QI process
4. Identify at-risk patients
5. Identify and manage ABCS population
6. Deepen patient self-management support
7. Link to evidence-based community resources
Healthy Hearts Northwest Setting

- Wide geographic spread of H2N, practices across rural and urban WA, ID, OR
- Enrolled 258 Practices
- Collaborative effort
  - ORPRN/OHSU
  - MacColl Center for Health Care Innovation, Kaiser Permanente Washington Health Research Institute
  - Qualis Health
  - WPRN, University of Washington
Early Takeaways

• Collecting ABCS data was a challenge
• There was considerable room for ABCS improvement
• Practices improved their ABCS metrics
• High retention of practices completing 15-month project
• QI was a team sport:
  “For every adult that walks in here, we, as a team, need to be thinking about the ABCS measures”… “It is not the driver that ultimately wins the race, it’s the pit crew.”
• The project brought about culture change:
  “The impact of H2N was larger than the cardiovascular measures; it changed the culture of the clinic.”
Innovations Shared Across Practices

• BP Checklist at the point of care
• Tobacco-Free Readiness Assessment form
• Use of EHR to track whether patients who smoke received smoking cessation counseling.
Innovations Shared Across Practices

• “Your Heart Health Guide” to increase patient self-management support.
Innovations Shared Across Practices

- Laminated hearts hung on exam room doors to indicate initially elevated BP reading for follow-up reading and discussion.

Red Heart Routine

**STEP 1**
- Take patient blood pressure. Enter result in EPIC.
- If blood pressure is less than 140/90 no further action is needed.

**STEP 2**
- If systolic is 140 or above or diastolic is 90 or above clip red heart to in-basket outside room.
- Notify patient that their blood pressure needs to be repeated before they leave the room.
- The red heart communicates to others that someone needs to repeat the blood pressure.
- Someone notes red heart and repeats blood pressure.
- Enter the second blood pressure in EPIC.
- Put red heart back in resting position.

Your Next Appointment:

**Date:**____________________

**Time:**___________________

**Before coming in:**
- Do not drink coffee or use tobacco products for at least 30 minutes before measuring.
- Do not exercise or eat a large meal two hours before measuring.
- Use the restroom. A full bladder can affect the reading.
Next Steps: Regional Improvement Collaborative

A forum for primary care practices and regional stakeholders to convene and share quality improvement activities.

What is it?

- 3-hour meeting with H2N practices sharing their experiences
- Discussions about ongoing regional QI efforts and opportunities for collaboration amongst RIC attendees

Who is invited?

- Providers and staff from practices in a given region
- CCO and other payer group representatives
- IPAs, public health or county health departments, local AHECs, OHSU’s rural campuses, and OHSU’s Community Research Coalition
Thank you!

Caitlin Dickinson, MPH  
H2N Project Manager  
summerca@ohsu.edu  
503.494.9106

Cullen Conway, MPH  
H2N PERC  
conway@ohsu.edu  
503.679.0455
Increasing HPV Immunization Rates: The Rural Adolescent Vaccine Enterprise (RAVE)

Funding Agency: American Cancer Society
Project Dates: July 1, 2018 – June 30, 2023
Project Manager: Caitlin Dickinson
What critical question does RAVE answer?

HPV is linked to many cancers. Though there is a vaccine that can prevent the spread of HPV infection, **vaccination rates fall far short of desired targets**. This comprehensive intervention study will shed new light on **how communities and primary care practices can improve immunization rates**.
How will RAVE impact healthcare?

Although the United States’ Healthy People 2020 Goal for completion of the human papilloma virus (HPV) vaccine series by age 13 to 15 years is 80%, only 40% of females and 21% of males currently complete it.
Study Design

A rigorous study design to test novel interventions in rural PCPs and rural community-based organizations designed to increase HPV vaccination completion in both males and females aged 11-17 years.

Aim I: Conduct baseline assessment

Aim II: Implement stepped-wedge, cluster randomized PCP-based intervention

Aim III: Implement evidence-based community-level intervention

Aim IV: Design and disseminate toolkit
# Our Experienced Project Partners

<table>
<thead>
<tr>
<th>Partner</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Patricia Carney, OHSU, Co-PI</td>
<td>Oversee qualitative and practice-level data, analyses associated with the Solberg Model</td>
</tr>
<tr>
<td>Dr. Brigit Hatch, OHSU</td>
<td>Lead exploratory aim, supporting practices and community partners in designing and implementing an evidence-based intervention</td>
</tr>
<tr>
<td>Dr. Michelle Berlin, OHSU</td>
<td>EXPERT: HPV vaccination strategies</td>
</tr>
<tr>
<td>Dr. Paul Darden, University of Oklahoma Health Science Center</td>
<td>EXPERT: Pediatrics, HPV, and other childhood immunizations, and practice-based research</td>
</tr>
<tr>
<td>Dr. Miguel Marino, OHSU</td>
<td>Design and direct the statistical analysis for the study</td>
</tr>
<tr>
<td>Oregon Immunization Program</td>
<td>Link to the Oregon AFIX program, develop relationships with clinics and health systems, implement effective immunization policies</td>
</tr>
</tbody>
</table>

**ORPRN:** Dr. LJ Fagnan, Dr. Melinda Davis, Katrina Ramsey, 2 ORPRN PERCS
Map of Setting

Target population: 40 small- to medium-sized primary care clinics in rural Oregon

*Rural areas have unique challenges regarding HPV and are understudied
Less access to pediatricians
Lower health literacy
Belief systems*
Next Steps

Finalize protocol
Submit IRB documents
Recruit practices
Enroll practices!!!
Launch study
Please contact us if your practice is interested in participating!

Caitlin Dickinson, summerca@ohsu.edu, 503-494-9106
Oregon Accountable Health Communities

Funding Agency: CMS
Project Dates: 5/1/17-4/30/22
PI: Bruce Goldberg, MD
What is the Oregon Accountable Health Communities (AHC) Project?

• 5 year CMS grant
• 9 rural counties
• 4 main components:
  • Screens for 5 social determinants of health needs: housing, utilities, food, transportation, interpersonal violence
  • Provides Community Resource Summary to those that screen positive
  • Navigate for a subset of high risk patients
  • Works towards integration of health and social services
Who in Oregon is Involved?

• Roughly 45+ clinical settings in the 9 counties- primary care, public health, dental, behavioral health, emergency medicine, etc.

• Social service agencies serving the 5 key social needs of the project- housing, food, utilities, transportation, violence

• All 6 CCOs: AllCare, Jackson Care Connect, PacificSource Central Oregon, PacificSource Gorge, Primary Health, Yamhill CCO

• Health Councils

• State Medicaid Office, Transformation Center, and other state agencies

• Vistalogic

• 211info
Design

• We are 1 of 32 grantees nationwide
• In Oregon:
  – 75,000 screens annually of Medicaid and Medicare recipients
  – 2,925 navigations annually
• All communities will be compared to control communities
• Outcomes of Interest: health outcomes and cost of care
How this study can impact healthcare:

• Better understand social needs of participating communities as well as of Oregon Medicaid and Medicare population
• Test feasibility and acceptability of multiple screening modalities & settings:
  • Email, phone call, in-person, self-screening by tablet
  • Primary care, public health, dental, behavioral health, hospital
• Better understanding of impact of addressing social needs on health and healthcare costs
• Support further integration of health and social services in Oregon
Next steps

- Project screening launches in May and goes for 4 years
Questions?

Bruce Goldberg, MD  
Principal Investigator  
503-975-8932  
goldberg@ohsu.edu

Anne King, MBA  
Project Director  
503-494-7994  
kinga@ohsu.edu
ORPRN Pillar #4: Education

- Support for ongoing learning
  - Connection to training
  - Telementoring
  - Technical assistance
Technical assistance (TA) for the Eastern Oregon Coordinated Care Organization (EOCCO)

Funding Agency: EOCCO

Project Dates: 2014 – present

Anne King, MBA
ORPRN’s role

• TA and administration for EOCCO Community Benefit program which reinvests quality revenue
  • Annual grants to LCACs tied to CCO incentive measures and CHIP plans
  • Transformation grants tied to CCO incentive measures, innovative pilots and new ideas
• Collaboration with Moda and GOBHI staff
EOCCO Coverage

- 12 counties
- Large geographic area
Community Benefit Reinvestment Program

• In its 4th year
• $5.7 million awarded-- over 150 grants
• Funding for projects, including:
  – Workforce & new models of care (CHWs, BH integration, paramedics, e-visits)
  – Care coordination and social determinants of health
  – Population health improvement (diabetes, hypertension)
  – Prevention (CCO incentive measures and others)
  – ED utilization
  – IT capacity (Arcadia)
Sample Outcomes

• Community Health Workers
  – Virtual training program (OSU)
  – Integration into & across primary care, ED, behavioral health, schools, public health
  – Largely sustained beyond the grants
  – EOCCO billing code
Sample Outcomes- “Opt-in” grants

• Adolescent Well Care Events
  – 9 counties now doing “events”
    • Multiple quality measures at one event (e.g. AWC, immunizations, effective contraception, dental sealants, SBIRT, depression screening, etc.)
  – Before program did not meet IM. After, met the 2016 & 2017 targets
  – Best practices spread across EOCCO
Sample Outcomes- “Opt-in” grants

• ED utilization-
  – Interventions with CHWs, integrated BH, PreManage
    • ROIs for these projects of 300% to 650%
    • Reductions in ED utilization, inpatient and observation costs

• CRC Screening
  – Before program did not meet IM. After, met the 2016 target. Implemented centralized FIT in 2017 and likely still met target.
Impact of collaborative approach

“Increased collaboration with one another has been the greatest impact coming from this project. Instead of looking at each other as competitors, we’re learning that collaboration...and sharing resources and knowledge provides for better results.”

“Not only are we now committed to functioning internally at a higher standard, we have also been able to improve the patient care and coordination of resources to all of our community members...”
Colorectal Cancer (CRC) Screening Technical Assistance

Funding Agency: OHA
Project Dates: 2016 – present
Melinda Davis, PhD
Three Key Dimensions - CCO and Clinic Partnerships Improve CRC Screening

Producing and Sharing Performance Data
(Accurate reports; Sharing – transparent and actionable; Used to prioritize action and monitor improvement)

Quality Improvement Process and Infrastructure
(Align plan: clinic efforts; Change via coaching, doing, funding; Structure – one-on-one and learning collaboratives)

Establishing Relationships & Partnership (History, Proximity, Process)

CRC interventions implemented

Unintended consequences:
• Focus on larger practices (missing small practices)
• Metric fatigue

Davis et al (In Prep) How do Accountable Care Organizations work with Primary Care Clinics to Improve Colorectal Cancer Screening? Relationships, Data, and Improvement Strategies.
TA Summary

• Phase 1 & 2 (completed 2016-2017)
  – Webinars & Consultation Calls (assess TA needed)
  – TA support: FIT education, direct mail programs, clinic workflows/partnership building, and member education

• Phase 3 (underway)
  – Learning Collaborative
  – Consultation
Webinar Resources


- Topics cover
  - Evidence behind screening options for CRC
  - Evidence-based interventions to increase CRC screening
  - Operationalizing direct mail programs – in practice and through health plan partnerships
  - Partnering with small clinics
  - Addressing disparities
CRC TA Well Received
(3rd Party Evaluation by OHSU)!

“[The webinars] have been phenomenal in helping us with resources and tools and even how to engage patients and providers in the conversation around FIT tests or whatever test is best perceived, that the patient will actually carry out. The information that we've gained from the webinars that have happened on the Medicaid side have been extremely informative across [all] lines of business.” (CCO 2)
For more information...


Thank you for this opportunity!
More may be on the way....

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Questions, Comments, Thoughts?

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The Oregon ECHO Network

Maggie McLain McDonnell, MPH
What is Project ECHO (Extension of Community Healthcare Outcomes)?

- **“Virtual grand rounds”** - a tele-mentoring program that combines 15-20 minute expert presentations with case-based learning
- Builds the capacity of primary care clinicians and clinical teams to manage common conditions that they typically refer to specialty care
ECHO Hubs and Superhubs: United States

Key: ECHO Hub Type (119)
- Superhub (6)
- Hub (104)
- U.S. DoD Hub (6)
- U.S. VA Hub (9)

Key: US State Shading
- ECHO Impact (42)
- Awaiting ECHO Impact (8)

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The Oregon ECHO Story

Map depicts 100+ organizations who have participated in ECHO in Oregon since 2014.

Map Design: Steven Brantley
Behavioral Health in Oregon

• 35% of Oregon’s population lives in rural or frontier areas

• Reduced Access to Care and Integration
  – Up to 6 month wait times
  – A shortage of clinicians
  – Lack of access to “pediatric, adolescent, and geriatric” behavioral health services

Source: 2017 Oregon Office of Rural Health Listening Tour
ECHO Offerings in Oregon

Previous offerings:
Child Development
EOCCO Community Health Worker Quality Improvement
Team-based Care for Integrated Primary Care Practice*

Program offerings for 2018 and 2019:
Hepatitis C and Liver Care
Nursing Facility Behavioral Health*
Substance Use Disorders in Ambulatory Care*
Adult Psychiatry I and II*
Child Psychiatry*
Chronic Pain and Opioid Use Disorder*
Tobacco Cessation
Geriatrics

* Address a behavioral health topic
Selected Oregon Results

• “Participating and learning about a complex chronic disease through ECHO is an effective way for our clinic to enhance its expertise.” (95% Child Psychiatry; 86% CHW; 96% PC MAT)

• Responding clinicians reported improved comfort in assessing and treating mood disorders and behavioral disorders; and prescribing depression, hyperactivity and inattention, anxiety, and insomnia medications (Child Psychiatry)

• 17% of responding clinicians provided 5 or more case consults to colleagues based on their participation (Primary Care MAT)

• 100% of participants said they would recommend ECHO to a colleague (CHW)
Oregon ECHO Network

• Statewide utility for ECHO programs and services, e.g. supports participant recruitment, evaluation, IT support, faculty engagement and contracting, curriculum development, delivery of sessions, CME for clinicians, Maintenance of Certification Part 2 for internal medicine

• “One-stop shop” website
  • Learn about ECHO opportunities
  • Register for programs
  • Access program materials and resources
  • Manage and receive no cost CME credits and nursing CEUs
Sponsoring Organizations

• CareOregon
• HealthShare of Oregon
• Oregon Department of Human Services- Aging and Peoples with Disabilities
• Oregon Health Authority
• PacificSource- Columbia Gorge CCO and Central Oregon CCO
• Providence Health and Services
• Trillium Health Plans
“All teach, All learn”

– Clinicians learn from specialists
– Clinicians learn from each other
– Specialists learn from practicing clinicians
Are you part of the ECHO?

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Thank you to our presenters!
Questions?