Care Coordination:
The View from ORPRN in 2013

Lyle J. Fagnan, MD

Six years ago ORPRN was funded through the Agency for Healthcare Research and Quality (AHRQ) to study the feasibility and acceptability of nurse-based care management in small to medium sized rural Oregon primary care practices. The study utilized the Care Management Plus program developed by Dr. David Dorr and colleagues. We conducted the study in six practices: four family medicine and two pediatric. In our proposal we noted that lifestyle, environmental changes, and the aging population have led to rapid increases in the number of patients with complex illnesses. These patients account for approximately 75% of health care expenditures and received appropriate treatment only about 50% of the time.

At the start of the study, the six practices had four care managers identified but, at study completion, there were 14 care managers working with their patient populations. We reported on barriers and facilitators to implementing care managers and enhancing coordination across the practice (see Turning Care Coordination: The View from ORPRN in 2013, Journal of Ambulatory Care Management, 2011). The barriers included role definition, resource concerns such as time and money, and the challenges of change and IT implementation. The facilitators included identifying the “the right person for the job”, leadership and accountability, developing a team-based approach, and practice facilitation from the ORPRN Practice Enhancement Research Coordinators (PERCs).

In 2013, care coordination is promoted as a foundational component of practice transformation. Coordination and Integration is one of the six core attributes in the Oregon Patient Centered Primary Care Home (PCPCH) Standards—“Help us navigate the health care system to get the care we need in a safe and timely way.” ORPRN is involved in multiple PCPCH practice transformation programs, including:

1. Safety Net Medical Home Initiative (SNMHI) – funded by the Commonwealth Fund, Qualis Health, and the MacColl Institute for Healthcare Innovation

2. Transforming Outcomes for Patients through Medical home Evaluation and re-Design (TOPMED) – funded by the Gordon and Betty Moore Foundation

3. Enhancing Child Health in Oregon (ECHO) – funded by the Child Health Improvement Patient Recovery Act (CHIPRA) Demonstration Grant Program to the Oregon Health Authority

4. The Comprehensive Primary Care initiative (CPC) – supported by CMS Centers for Medicare and Medicaid Innovation (CMMI)

5. Patient-Centered Primary Care Institute (PCPCI) – supported by the Oregon Health Authority and the Oregon Health Care Quality Corporation

ORPRN has participated in learning sessions and provided technical assistance to facilitate practice transformation for over 30 practices, including building the practice capacity and effectiveness for care coordination. The SNMHI change concepts have addressed care coordination as a means to reduce care fragmentation in primary care by integrating behavioral health, addressing effective care transition and referral plans, establishing effective channels of information transfer, and developing relationships with outside providers and community

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resources. As part of the SNMHI, OHSU Family Medicine at Scapoose and St. Luke’s Eastern Oregon Medical Associates were described as exemplars of care coordination in rural settings. Although practice context may be unique, the approach used to support care coordination within each practice frequently involves a high level of teamwork. How these teams are identified and developed varies considerably but reflects how practices think about care coordination.

ORPRN’s newsletter introduces care coordinators from St. Luke’s Eastern Oregon Medical Associates, Winding Waters Clinic, Springfield Family Physicians, Samaritan Family Medicine, and Santiam Medical Associates. Their profiles are brief, but tell of the varied roles they play in their practice. ORPRN functions as a connector, enabling practices to learn from each other. It is not uncommon to have care coordinators, practice managers, and other staff visit another ORPRN practice to learn about care coordination and teamwork. This highlights the value of a practice-based research network such as ORPRN as an effective learning and practice transformation organization.

We have much to learn about effective care coordination in primary care practices. The voices of the care coordinators are providing initial guidance and advice. At a recent telephone conference of the eight practices participating in ECHO, Kate Barrett, Care Coordination Team Leader at Winding Waters Clinic, shared perspectives that highlight the need for continuous quality improvement for care coordination and the challenges of keeping up with the rapid changes occurring in our primary care practices:

“Care Coordination takes a lot of time and effort and is exhausting.”

“Caution: Care Coordination can be a dumping ground for everything.”

Kate’s words provide an opportunity for practices to reflect on and share stories on what care coordination looks like in their practice.

Around Oregon

Paul McGinnis, MPA
Paul accepted a position with the Eastern Oregon Coordinated Care Organization (EOCCO), which includes Greater Oregon Behavioral Health, Inc. (GOBHI) and Moda Health. Speaking to the ORPRN team, Paul said, “I am excited about returning to my roots in health policy and community health development supplemented with a healthy respect for and a dose of research.” Please join us in thanking Paul for his years of service to ORPRN and wishing him well.

Madras Medical Group
An article about MMG’s decision to go pharma-free appeared in The Bulletin out of Bend. Writer Markian Hawryluk reports on the world of drug reps and the history of MMG’s experience leading to the decision. If you are curious about how the clinic arrived at this decision or want to take a look at some market research statistics, this is a great read: http://www.bendbulletin.com/article/20130715/BIZ0102/307149998/

Kevin Johnston, MD
The 2013 OHSU School of Medicine Community Preceptor Award was presented to Kevin A. Johnston, MD, of High Desert Medicine Clinic in Burns. An OHSU School of Medicine Graduate, Dr. Johnston is recognized for his dedication and service to medical students. As “affiliate” faculty, he has taught students in both the rural clerkship and summer observership programs. Says Dr. Johnston, “Teaching medical students is a part of my professional life that brings me the greatest joy.”

Andrew Janssen, MD
Andrew Janssen, MD, was named 2013 Home Care Physician of the Year by the Oregon Association for Home Care. Dr. Janssen practices at Blue Mountain Hospital’s Strawberry Wilderness Community Clinic in John Day. He cares for nursing home patients, jail inmates, and home health and hospice patients in their homes. Dr. Janssen also hosts OHSU students and residents. Quoted in the Blue Mountain Eagle, Sylvia Dowdy, BMH Home Health/Hospice director, said, “He does so much for our small community, and our health care couldn’t be half as good without him.”
Building a Medical Home in Small Rural Practices

Highlights from the Eastern Oregon Learning Collaborative

by Jill Currey and Melinda Davis

Participants from six practices in Eastern Oregon gathered in August at St. Luke’s Eastern Oregon Medical Associates (EOMA) in Baker City to participate in the third and final meeting of the Eastern Oregon Learning Collaborative. Supported through a contract from the Oregon Health Authority and Quality Corp, ORPRN is one of four groups providing technical assistance to 25 practices as they transform into Patient Centered Primary Care Homes (PCPCH).

Since February, participating clinicians have been working with Paul McGinnis, Jillian Currey, and Molly DeSordi in quarterly learning community meetings, monthly webinars, and regular internal quality improvement meetings as they tackle initiatives supporting PCPCH transformation. Topical experts, including Melinda Davis, PhD, David Buckley, MD, MPH, and Ron Stock, MD, have come to discuss leadership, patient engagement, team-based care, adaptive reserve, and integrating primary care and behavioral health. Prior to the initiative, none of the practices had submitted their PCPCH attestation. Now all six clinics are either recognized or have submitted applications to the State. During the final meeting in Baker City, participants reflected on both challenges and highlights from their efforts. These small rural practices noted various successes in practice transformation, such as:

- building team-culture by introducing morning huddles and care teams
- improving reporting and tracking of quality measures
- meeting practice staffing needs by adding care coordinators and practice managers

Conversations across the clinics during the learning collaborative created opportunities for sharing job descriptions and best practices. Support from the ORPRN Practice Enhancement Research Coordinators (PERCs) helped the clinics make progress toward their PCPCH transformation goals.

Learning collaborative participants noted key challenges around building a culture that embraces change as part of routine practice. Many clinics experienced setbacks in change efforts based on staff turn-over. Practices noted staff and clinician stability can be a challenge to embracing PCPCH concepts as people are asked to alter the way they provide care.

"Our staff has been working in the practice for an average of 10 years. When you get used to doing something well it can be challenging to get individuals to change those practices.” Kevin Johnston, MD – Harney District Hospital Family Care

"We have a practice with four staff members, and we lost 50% of them in the last month to deal with family crisis. We are now hiring new staff members and paying them more – because we’ve decided we need higher levels of skill.” - Sharon DeHart, PA – White River Health District (below)

“Though planning is possible, staff resistance can make changes difficult…” Kim Montee, MD – Union Family Health Center

Many of the challenges to transformation were echoed during the panel discussion by EOMA practice members. Clinicians, practice management, and diverse staff members discussed their journey to a Patient Centered Medical Home (PCMH). After a full day of learning and reflection, Eastern Oregon Learning Collaborative participants emphasized that PCPCH transformation will not end when the project comes to a close. Instead, the time together has set a foundation for embracing ongoing change.

“Practice transformation is not a destination; it is a change in mindset.” Mindy Binder (CEO) on behalf of David Collins, PA – Columbia River Community Health Services

### Clinic Details

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RHC=Federally Qualified Rural Health Clinic

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Panel Reflects on Lessons Learned over Eight Years of Practice Transformation

by Jill Currey and Melinda Davis

St. Luke’s Eastern Oregon Medical Associates (EOMA) has been working towards transformation to a Patient Centered Medical Home (PCMH) for more than eight years. Initially an independent practice led by four physicians, EOMA is now part of the St. Luke’s Hospital system. They have worked on many initiatives to convert to a PCMH, including participation in the Qualis/Commonwealth Safety Net Medical Home Initiative and Enhancing Child Health in Oregon (ECHO), a Children’s Health Insurance Program Reauthorization Act (CHIPRA) Demonstration Project in Oregon. A highlight of the Patient Centered Primary Care Institute (PCPCI) Eastern Oregon Learning Collaborative was a panel of EOMA clinicians and staff reflecting on their experiences.

EOMA participants included:
• Kathy Robbins, RN: Diabetes educator, RN manager
• Mary Stearns, RN: Nurse Care Manager
• Michelle Dix, CNA: Care Coordinator
• Cindy Denne: Office Manager
• Rayna Peyron, MA: MA for Dr. Schott
• Nancy Anderson, LPC: Mental Health provider
• Jon Schott, MD: St. Luke’s Regional Medical Director

Facilitated by Jill Currey, MPH, and Paul McGinnis, MPA, panel participants emphasized the following elements as critical for practice change:

• This work took time! Clinic staff were engaged throughout the eight year journey.
• “(Our PCMH) is not something that started on day one – this is something that we’ve grown into.” John Schott, MD
• Engaged leadership is key. A unified vision among clinical leadership created momentum for practice changes. However, be open to ideas and suggestions from all individuals in the clinic, not just designated “leadership.”
• Provide meeting time for all staff, not just practice leadership. Initially the practice had provider meetings, but now they have protected clinical hours for nursing meetings, front office meetings, full staff meetings, and committee meetings (which engage front and back office staff members as well as clinicians).
• Implement change in small teams and use success strategies to motivate spread across the practice. It is critical to get staff members on board by engaging them in the planning process to develop the change, not just doing the final activity.
• Having a stable financial structure helps create opportunities for change. Clinic leadership needs to reinvest in the organization to support practice change.
• A relationship with OHSU kept their standard of care at a high level. They embraced study opportunities with ORPRN to support their vision for change, including care management, diabetes education, and PCMH.
• Give yourselves credit for what you’re doing. Celebrate small changes and use resources; practice change is not the only thing you’re focused on day-to-day. “Use your PERCs; they can help keep you on task.” - Cindy Denne
• Continually educate staff about PCMH and use multiple strategies. When hiring new staff, EOMA talks about the services they provide as a PCMH and how they work as a team. They also use live skits during staff meetings to emphasize PCMH components (e.g., modeling how care managers help support clinicians with patient care).
• Invest in your staff; this can mean having difficult conversations about performance. Focus on matching people with what they do well. EOMA staff fill multiple roles in the practice and were able to progress in their roles as the organization grew.
• “I openly admit that I underestimated the impact of change on staff. Change fatigue is a real issue. As you’re leading this, you need to pay attention to the vibe you’re seeing in your staff.” - Jon Schott, MD
• Put the patient first. Build teams to help address patient needs. The clinic is working to integrate mental health and expand to address behavioral health care. They are also changing visit workflow to engage support staff (e.g., doing co-visits or warm handoffs to care coordinators, the diabetes educator, or mental health providers).
• “We treat our patients like they are our family.” - Mary Stearns, RN
Meet a Few of Our Care Coordinators . . .

Kate Barrett, pictured here with an IT student, James) is the Care Coordination Team Leader at the Winding Waters Clinic in Enterprise. Kate says her role is “fluid” as she assists with filling prescriptions, arranges referrals, and obtains prior authorizations from insurance. She also does traditional patient care. Says Kate, “We want to expand our care coordination scope, and make sure each of our patients feels the blanket of care cover them, while at the same time keeping the practice alive, vital, and fiscally responsible.”

Diane Puppo, RN, is a Care Coordinator for Samaritan Family Medicine Resident Clinic in Corvallis with 12 years of Family Medicine experience. The position has been evolving over the past several months. She reaches out to patients, calling those that have been seen in ER or the hospital, and assists with patient needs in the clinic. “I can be a nurse, social worker, health coach, ear to listen . . . you name it,” says Diane. She helped implement a Pre-Diabetic education group offered at the clinic through their diabetic educator and nutritionist. She started a PDSA group at her clinic. Diane is working with Good Samaritan Regional Medical Center to streamline the discharge process from inpatient to outpatient. “We are constantly working on ways to improve care.”

Debbie Turrell, RN, supports the Patient-Centered Primary Care Home (PCPCH) at Santiam Medical Associates in Stayton in her role as Care Manager. Among her many responsibilities, she engages patients and their families in self-management care plans, completes health risk assessments as a foundation for care plans, facilitates access to medical home providers and resources, and acts as the primary contact for patients and community partners. She also assists the care team in evaluation and quality improvement.

Elizabeth “Lizzy” Lobosky, LPN, works with a multi-disciplinary team to identify high-risk patients at Springfield Family Physicians. She develops provisional care plans, and works with providers and patients to tailor plans that incorporate patient-specific goals and needs. She monitors and manages hospital and ED transitions of care, and performs medication reconciliation. The clinic is currently participating in two ORPRN studies: TOPMED and CPC (see page 1). Care plans developed by Lizzie have been deemed by the TOPMED evaluation team as a best practice and were shared by the Comprehensive Primary Care Initiative technical assistance group to Oregon.

Mary Stearns, RN, BSN from St. Luke’s Eastern Oregon Medical Associates, does initial nursing/needs assessments, and monitors high risk patients. Her duties include medication reconciliations, adherence, effectiveness and toxicity. She assists with mental health referrals/supportive interventions, links patients to community education and outreach, and advocates for patients and their families. She has participated in several ORPRN care management studies.

Self-management Support

Implementing Networks’ Self-management Tools Through Engaging Patients and Practices (INSTTEPP) will implement and evaluate the AHRQ Self-management Support Library/Toolkit. A collaboration between PBRNs in Oregon, Colorado, Iowa, and Wisconsin, the study will take place in 16 practices across four networks. Colorado-based SNOCAP will lead the Boot Camp Translation (BCT) intervention, built on the principles of community engagement. Patients, care managers, clinicians and staff will become experts in patient self-management, and will implement these tools in their practices. We will assess the impact of BCT through pre- and post-surveys and observation.
Stayton physician cares for Syrian refugees

by Paul Neumann and Nancy Rollins

Paul Neumann, MD, from Santiam Medical Associates in Stayton, travelled to Lebanon this year to treat Syrian refugees and work to develop a sustainable program for this population. Says Dr. Neumann, “I am looking at models for the mobile medical units (MMUs)—the teams that travel from camp to camp. I am struck by a need for coordinating care beyond the ‘treat them and street them’ that we are often forced to do.” MMUs are composed of doctors, nurses, and translators. The nurses act as pharmacists and health educators as well as providing wound care and other services.

The Syrian refugees Dr. Neumann treated reside in multiple camps in the Bekaa Valley, east of Zahle, Lebanon. His medical team was present from May through June this year, working daily with Humedica, a German humanitarian organization. The team collaborates with several NGOs, The United Nations High Commissioner for Refugees (UNHCR), also known as the UN Refugee Agency, and the Lebanese Ministry of Health on day-to-day operations. Medical Teams International (MTI) and Humedica are responsible for approximately 30 camps, each with a unique demographic, different leaders, and different levels of infrastructure. Camp residents vary from hundreds to thousands.

Besides providing medical care, the team meets with local organizations, interviews and surveys refugees, and collects personal observations. Collaboration is focused on achievable short term and long term goals.

Given the ongoing conflict in Syria, a continued influx of refugees is highly likely. The team’s host organization, Heart for Lebanon, suspects the government views NGOs as competing with the local health care economy, offering free care to Syrians that is not available to Lebanese citizens. For this reason, the MMUs do not manage chronic diseases but refer patients to the Lebanese Primary Health Clinics (PHC). Syrian refugees who are under the age of 5, over 60, or pregnant can register to receive access to local clinics at a discount.

The Bekaa Valley is home to many NGOs, local hospitals and clinics, and the Lebanon Ministry of Health. Dr. Neumann would like to see these groups share medical resources and coordinate care.

“Patients with chronic disease, acute diseases, or requiring hospitalization present a unique challenge to currently available care. About 5% of the patients seen require secondary care. Additional staff, such as a social worker to coordinate care and a medical educator to identify and address general and specific health issues, might better serve the population’s needs. Creation of a coordinated vaccine program for preventable diseases such as measles, and a record keeping system for refugees, would also provide benefit. Dr. Neumann believes that medical care can continue with the current model of ‘essential primary care’ or may expand to a ‘comprehensive primary care’ model.

“The Middle East is a tangle of beliefs, history and sometimes blood and violence. The more I learn of the people and history, the more complex these issues are and the more confused I become about who is right and who is wrong. These important questions and sticky concerns dissolve when I see the bright smiles and trusting eyes of the Syrian refugee children. These faces and young lives are the future of Syria and of this volatile region. We cannot forsake them.” - Paul Neumann, MD

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‘Essential primary care’ is basically first aid and treatment of acute and self-limited diseases. Dr. Neuman explains, “This is the current clinic level of care. Patients requiring referrals or additional care are given general recommendations and information on how to seek care elsewhere and are left to their own devices to do so. Our experience thus far is that most do not follow through with these recommendations for several understandable reasons including expense or paranoia. The other option would be to provide ‘comprehensive primary care.’ This model would continue the ‘essential primary care’ as currently provided by mobile medical units. However, the team would be augmented by a social worker and health educator. Ideally the social worker and health educator would be local Lebanese or Syrian individuals that could integrate long term into the program.”

Social workers could coordinate care between patients and the various programs that are available for special populations. For example, the social worker may arrange transportation to the hospital and connect a patient with an organization that may cover their hospital expenses. The social worker would also be responsible for longitudinal follow up on at-risk patients (such as children with diabetes) and ideally, to establish these patient in the local health care system.

Dr. Neumann is interested in creating and implementing a comprehensive primary care model and determining its effectiveness by pre- and post-implementation data collection.

Dr. Neumann’s photos and writing are available at: http://caringaround.blogspot.com/

A History of Charitable Work

Dr. Neumann has made many mission trips, travelling up to four times a year. Charitable work is a commitment that he shares with his practice partner of six years, Guesly Dessieux, DO. Dr. Dessieux volunteers frequently in Haiti, his country of birth. He was joined there by Dr. Neumann after the earthquake in 2010. Dr. Dessieux and Dr. Neumann travelled at the start of 2013 to Niger. Dr. Neumann travelled in 2012 with Medical Teams International to assist Somalian and Kenyan refugees displaced by al-Shabaab. Treating sepsis, gunshot wounds, and malnourished babies, Dr. Neumann pointed out in an interview for Chart Notes, the Marion-Polk County Medical Society newsletter that “chronic disease barely exists in this part of the world. You don’t survive after a stroke or ‘live’ with diabetes.” Travelling to Somalia the same year, Dr. Neumann again treated refugees, these in a camp along the border with the Democratic Republic of Congo, after their town was seized by rebels. Although the team could test for pregnancy, screen for malaria and HIV, most of what they saw were parasitic infections, malnutrition, and trauma. Dr. Neumann also travelled to Uganda in 2012 to provide acute and chronic care to Congolese refugees.

The doctors credit Nurse Practitioner Kathleen Thurman and Physician Assistant Ann Gould for their coverage of the clinic while they are away.

Baker City Doctor Takes Medical Teams to Honduras

Jon Schott, MD, from Eastern Oregon Medical Associates, and his wife Dawn, have taken medical teams to Honduras every year since 2000. Over the years the team has grown in size and now includes physicians, dentists, NPs, PAs, EMTs, dental assistants and students. Beginning next year, two teams will go each year. Dr. Schott has coordinated with True Disciples from Washington for coordination and support. In Honduras, the team provides general medicine and dental care in up to seven clinics. Honduras is among the poorest countries in Latin America, with poverty and food scarcity severe in rural areas. About one in five Hondurans lack access to health care, one in 10 lacks access to safe water, and one in four experiences chronic malnutrition. For more information about True Disciples work in Honduras, visit: http://www.true-disciples.com/february-2012-news
The Next Step in Enhancing Patient Care

by Jill Currey

For the past two years, St. Luke’s EOMA has been an active participant in Enhancing Child Health in Oregon (ECHO), a Children’s Health Insurance Program Reauthorization Act (CHIPRA) Demonstration Project funded by the Center for Medicare and Medicaid. Along with seven other practices in Oregon, they partnered with facilitation support from ORPRN to engage in medical home transformation focused on Children and Youth with Special Health Care Needs (CYSHCN).

The clinic is very interested in taking a more in-depth approach to learning about patient experiences to care. After several months of logistical preparation, the patient experience workgroup launched their first Patient Advisory Council (PAC) meeting in August. Five patient representatives—ranging from parents with children/youth having special health care needs to active retirees—participated in a lunch meeting to learn how they can improve patient experience at St. Luke’s EOMA. The goals of the Patient Advisory Council are:

- Transform the patient’s experience by achieving the Triple Aim: Better health, better care, and lower costs
- Improve the patient experience of care (including quality, engagement and satisfaction)
- Determine strategies for engaging patients in assessing family strengths, setting goals, and identifying and addressing barriers in the context of developing shared care plans for CYSHCN
- Create an improvement strategy for ongoing use of feedback based on practice-level results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and St. Luke’s Patient Centeredness surveys
- Determine plans to spread PAC partnership strategies, tools and resources among all staff at St. Luke’s EOMA

The staff at EOMA is excited about this next step to enhance the patient experience, and the patient members are also energized and empowered to be part of the team. Some reasons patients are excited to join the PAC:

“I would like to throw out suggestions that would make it easier on others... with things that would be helpful medically... it may not make a big impact on my family, because they love to come here (St. Luke’s EOMA) . . . and we are over the hump . . . but to make it easier for another family to get others over the hump and to have their kids love to go here too, that would be enough.”

“Because I have had some bad experiences out here... the system is broke, but it can be fixed and that’s why I’m here . . . I want to see it fixed.”

The meetings provide a place to share ideas, suggestions and constructive criticism with solutions that will benefit the patients, EOMA staff and community. The PAC meets monthly at St. Luke’s EOMA in Baker City. To inquire about EOMA’s PAC, contact Cindy Denne at deneci@slhs.org.

ORPRN PCPCH Medical Home Rap

Hosted by the Patient Centered Primary Care Institute (PCPI) Technical Assistance Expert Learning Network, more than 40 health care professionals met in July to network with other primary care home experts, share tools and resources, and discuss methods of providing support and practice facilitation. Organizations were invited to share their expertise and current work with practices. Written by Jill Currey, MPH, the "ORPRN PCPCH Medical Home Rap" was performed by Jill, Beth Sommers, MPH and Melinda Davis, PhD. For more information about PCPI, visit http://www.pcpci.org.

(We put the fun in practice transFUNmation)