Enhancing Child Health in Oregon (ECHO) Through the Implementation of a Medical Home Learning Collaborative

CORE ECHO TEAM: 1. Oregon Pediatric Improvement Partnership (OPIP)**:** *Colleen Peck Reuland, R.J. Gillespie, David Ross, Katie Unger, Kiara Siex, Neil Braun* | **2.** OPIP/ECHO Parent Partner: *Alicia DeLashmutt*
3. Oregon Rural Practice-Based Research Network (ORPRN) Team*: L.J. Fagnan, Paul McGinnis, LeAnn Michaels, Jillian Boyd, and Molly DeSordi.* | **4.** Oregon Health Authority, Office of Health Analytics: *Charles Gallia* & Office of Health Policy and Research: *Oliver Droppers.*

Key Components of ECHO

LEARNING COLLABORATIVE: Public/private stakeholders developed goals and objectives for the learning collaborative. The ECHO team developed a Learning Curriculum (LC) to ensure a focus on identification of children and youth with special health care needs (CYSHCN) and care coordination. Additional learning topics were based on opportunities for improvement identified through baseline data.

PARTICIPANTS: The team recruited eight private practices that serve children enrolled in Medicaid/CHIP. Five are pediatric practices, three are family medicine practices; two are in urban areas, three in suburban areas and three in rural. One of the practices was purchased by a larger system over the course of the project. OPIP facilitated five sites and ORPRN facilitated three sites. The practices received an annual stipend of $7,000 to cover expenses related to Learning Collaborative meeting attendance.

EVALUATION TOOLS: Office Report of Systems and Processes: 1) Medical Home Index: Revised Short Form© (MHI-RSF©), a tool specific to Children & Youth with Special Health Care Needs; 2) National Committee for Quality Assurance Patient-Centered Medical Home (NCQA PCMH™); 3) Oregon Patient Centered Primary Care Home (PCPCH) attestation data were collected at baseline (November '11) and when the practice re-attested.

PATIENT EXPERIENCE OF CARE DATA: OHA sponsored collection of Consumer Assessment of Healthcare Providers & Systems®, Clinician & Group, Patient Centered Medical Home (CG CAHPS® PCMH™) in Fall 2012. Data are now being collected for Fall 2014.

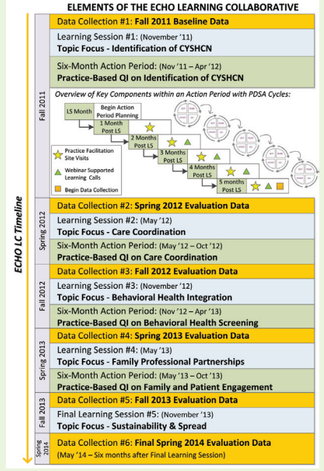
Key components of ECHO's Learning Collaborative:

Five full-day, in person Learning Sessions (LS) focused on specific characteristics of high-functioning Medical Home. Sessions included patient keynote speakers, OHA participation to inform policy change, and strong participation from the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) as a critical teaching partner.

- Standardized evaluation data collection across sites that were shared and used to inform QI efforts.

FOLLOWING EACH LS:

- Targeted QI efforts focused on a specific LS topics.
- Monthly webinars where practices shared their progress and challenges to allow for cross-site learning.
- Monthly site visits with a skilled practice facilitator from OPIP or ORPRN, and regular e-mail consultations.



ECHO's Impact on Policies in Oregon

IMPROVEMENTS TO OREGON'S PATIENT-CENTERED PRIMARY CARE HOME (PCPCH) STANDARDS

- Members of the ECHO team serve on the PCPCH Steering Committee and have shared lessons learned from the ECHO initiative. OPIP convened public/private stakeholders and shared white papers summarizing feedback from practices and offering suggestions for improvement to the standards. A number of recommendations were included in the updated 2014 standards, and the September '14 preliminary draft of the 3 STAR program. The 3 STAR designation is meant to acknowledge clinics that are trailblazers in practice transformation.

STRUCTURE & FOCUS OF THE PATIENT-CENTERED PRIMARY CARE INSTITUTE (PCPCI)

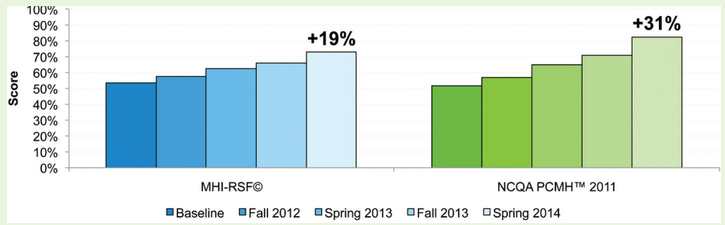
- OPIP and ORPRN are technical assistance providers within PCPCI and have disseminated learnings from ECHO to the Institute.

CHILD- AND FAMILY-CENTERED INCENTIVE METRICS

- Metrics & Scoring Committee: An ECHO team member is one of nine appointees to this committee, and has used insights from ECHO to inform the work of this group.

Practice Transformation in ECHO

- Practices transformed their level of medical home services. Practices improved on NCQA PCMH™ 2011 (+31%) and care specific to CYSHCN as assessed by the MHI-RSF© (+19%).
- Across the practices, they improved the most on standards related to population health and care management (NCQA Standard of Plan & Manage Care -+42%) and access to care and continuity with personal doctor or nurse (NCQA Domain Enhance Access & Continuity - +36%).
- For CYSHCN, practices improved on care coordination (+26%), outreach to community based providers (+25%), and their organizational capacity to care for CYSHCN including their mission and models of team based care(+20%).
- All eight of the practices have achieved Tier 3 status on the Oregon PCPCH standards. The ECHO practices are in the top 25% of all practices that have attested.



Enhanced Medical Home Across the Practice

ECHO practices improved on 746 processes assessed by NCQA PCMH™ 2011. A majority of ECHO practices improved in numerous patient care processes, including:

- **TEAM-BASED CARE:** *Development of teams and creation of care plans with patients.*
- **USE OF SURVEYS:** *Meaningful collection and use of patient experience of care data (CAHPS® CG PCMH™)*
- **POPULATION MANAGEMENT:** *Establishment of criteria and process to identify persons with special healthcare needs.*

Enhanced Care Coordination & QI Infrastructure - Partnership With Patients

At the beginning of ECHO, three practices had an in-house care coordinator. During the project, all eight practices hired a care coordinator. As of Spring 2014 (six months after the end of ECHO), seven of the eight practices have maintained their care coordinator positions.

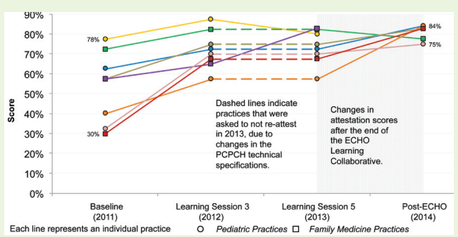
- Seven out of eight have engaged the full practice staff (leadership and office staff) on medical home and the ECHO project. This includes periodic clinic-wide communication and spread of improvement efforts across the practice.
- Five out of eight practices now have an advisory committee of patients and families that is a vehicle for input and guidance on the quality strategy and improvement efforts within the practice.
- At the Final LS , 83% of participants reported being confident in continuing transformation work in their practice. Spring '14 follow-up evaluation data collected six months after the project ended showed sustained improvements in the practices with no significant declines in scores.

Improvements for CYSHCN

ECHO practices improved on 206 processes assessed by MHI-RSF©. Below are processes for which all 8 practices improved:

- **MISSION OF THE PRACTICE:** Policies that ensure family-centered care, and that assess the needs of CYSHCN and their families.
- **CYSHCN FAMILY FEEDBACK:** Collect and share feedback from families of children with special health care needs.
- **CARE COORDINATION/ ROLE DEFINITION FOR CYSHCN:** Care coordination to families of CYSHCN.
- **CYSHCN FAMILY INVOLVEMENT:** Asking families what care supports they need and collaborating with families on performing care coordination activities.

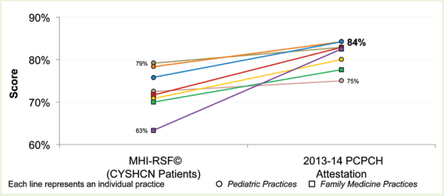
All ECHO Practices Achieved Tier 3 PCPCH Status



High Value Components of ECHO

- Practices ranked the monthly facilitation visits (72% extremely useful) and the in-person Learning Sessions (71% extremely useful) as the most beneficial components of the LC.
- Practices highly valued the OHA-sponsored collection of the CAHPS® CG PCMH™ and reliable, valid, and standardized data it provided about their patient's experience of medical home processes.
- Informing Policy: Among the practice staff that attended the final learning session, 83% agreed that ECHO improved their understanding of state-level policies and health reform; 64% agreed that ECHO increased their ability to inform improvements in state-level policies.

General Medical Home Transformation Doesn't Always Lead to Improved Care for CYSHCN



- Practice scores varied significantly between the tool assessing general medical home processes, and the tool assessing medical home processes for CYSHCN specifically.
- Practices who have general medical home capacities and processes don't necessarily have them in place to meet the needs CYSHCN.

Tri-State Effort

The Tri-state Children's Health Improvement Consortium (T-CHIC) is an alliance between the Medicaid/CHIP programs of Alaska, Oregon, and West Virginia, formed with the goal of improving children's health care quality. T-CHIC represents 3 of the 18 states participating in the federal CHIPRA Quality Demonstration grant program. ECHO is one component of T-CHIC.

ECHO's Impact on National Policies

CHIPRA DEMONSTRATION: Learnings from ECHO/TCHIC are informing national discussions about CHIP and health reform efforts.

NATIONAL MEDICAL HOME STANDARDS: The T-CHIC team drafted and disseminated memorandums to inform improvements to the NCQA and CAHPS tools. OPIP staff will present key learnings from ECHO at an NCQA meeting on patient engagement.

CHIPRA CORE MEASURES: Lessons learned from ECHO and T-CHIC are informing discussions about the relevance and meaningfulness of the core measures for practice-level medical home transformation. Through T-CHIC, Ms. Reuland (ECHO team member from OPIP) has been able to maintain her role as Measure Steward for the Developmental Screening in the First Three Years of Life CHIPRA measure.

NATIONAL EVALUATION BRIEFS: Of the nine briefs developed by the CHIPRA National Evaluation Team, ECHO has been spotlighted in four (# 2, 4, 6, & 9). Areas of innovation highlighted include the evaluation methods, impact on child health policies, multi-state and multi-stakeholder collaborations, and models for improving care coordination. http://www.ahrq.gov/policymakers/chipra/demoeval

Questions? Need More Information? Contact **Colleen Reuland** | reulandc@ohsu.edu | (503) 494-0456

OPIP ORPRN