Enhancing Child Health in Oregon (ECHO)
Advancing Transformation and The Triple Aim

Portland State University
Smith Memorial Student Union (Room 238)
1825 SW Broadway - Portland, OR
8:00 AM - 12:00 PM

ECHO is a project of the Tri-State Children's Health Improvement Consortium (T-CHIC) & Supported by the Oregon Health Authority

ORPRN

OPIP

GOALS FOR TODAY

1. Learn about the impact of ECHO on transforming care provided to children and adolescents
2. Discuss the factors that facilitated or impeded transformation
3. Identify policy opportunities to spread and sustain best practices

AGENDA

- Welcome and overview – Diana Bianco, Artemis Consulting
- ECHO Project: Description and context – Charles Gallia, OHA, & R.J. Gillespie, OPIP
- What we learned/ECHO outcomes: What changed for participating practices and their patients?
  - The numbers and the stories behind the data – Colleen Reuland, OPIP
  - Reflections from participating providers: video
  - A parent perspective – Alicia DeLashmutt
  - Reflections from the practices: what helped and what got in the way – L.J. Fagnan, ORPRN
- Lessons learned for dissemination and spread – Oliver Droppers, OHA

Break

- Moving forward: How the lessons learned from ECHO can help achieve the Triple Aim
  - Group discussion on policy implications
- Reflections from legislators
- Summary and next steps

ECHO Project: Description and Context

Charles Gallia, Oregon Health Authority

Brief Overview

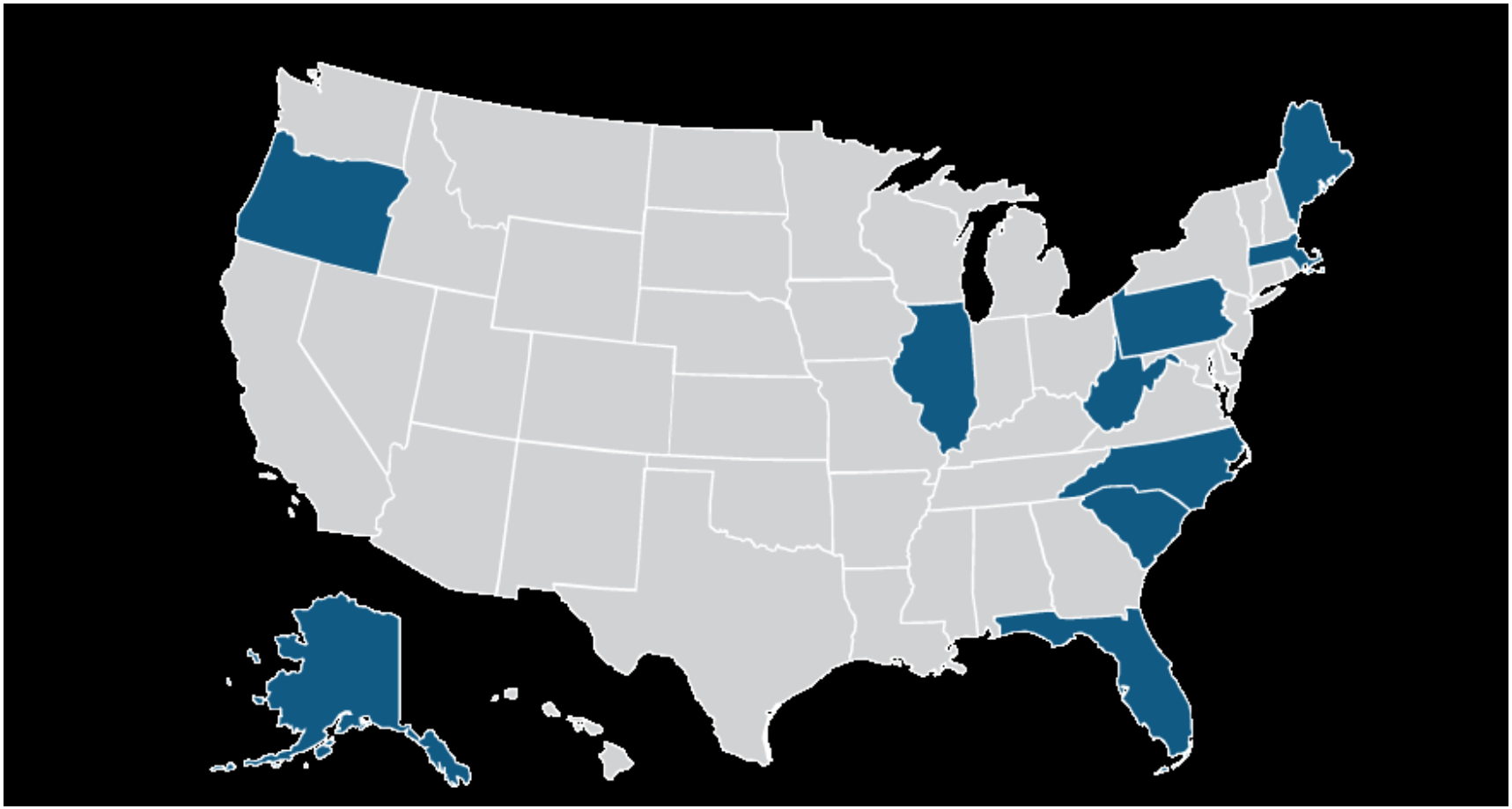
- Evolving Federal - State Health policy relations
  - Breakthroughs – usually by population's need
    - Aged and Medicare
      - Other Deserving Poor and the Medicaid 'sleeper amendment'
    - Proliferation of SSA Waivers
    - Balance Budget Act 1997*
    - CHIP
      - then CHIPRA

Changed Relationship

- Tensions and Trust
  - Reactions – regulate and audit.
    - Suspected patients, providers, insurers, & states
    - Measure, Monitor, and Manage
  - Enter newer era, based on partnership and delivering as promised
- A change in tone with this new administration
  - Listening
  - Learning

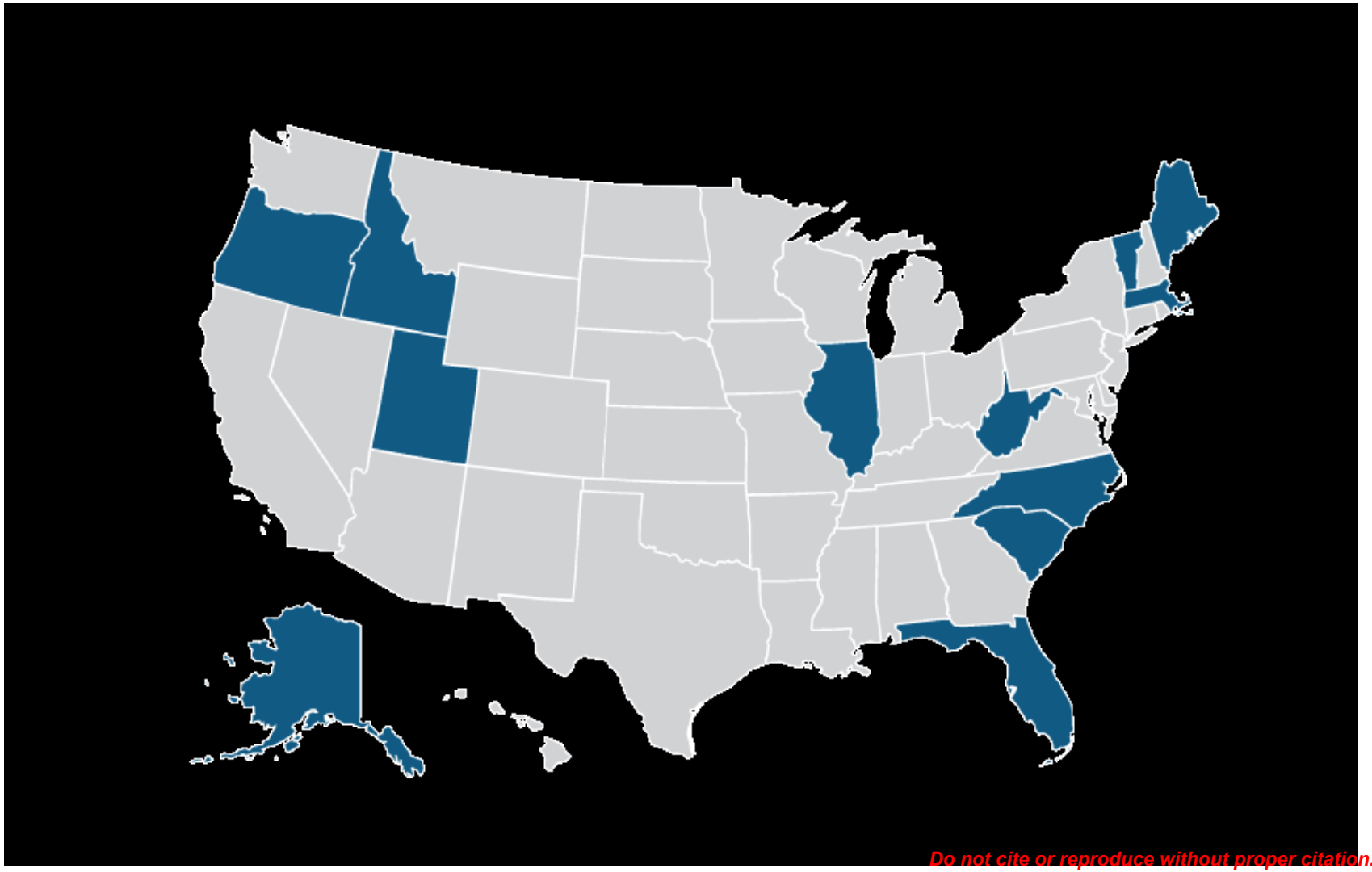
CHIPRA 2009

States emphasizing Quality Measures

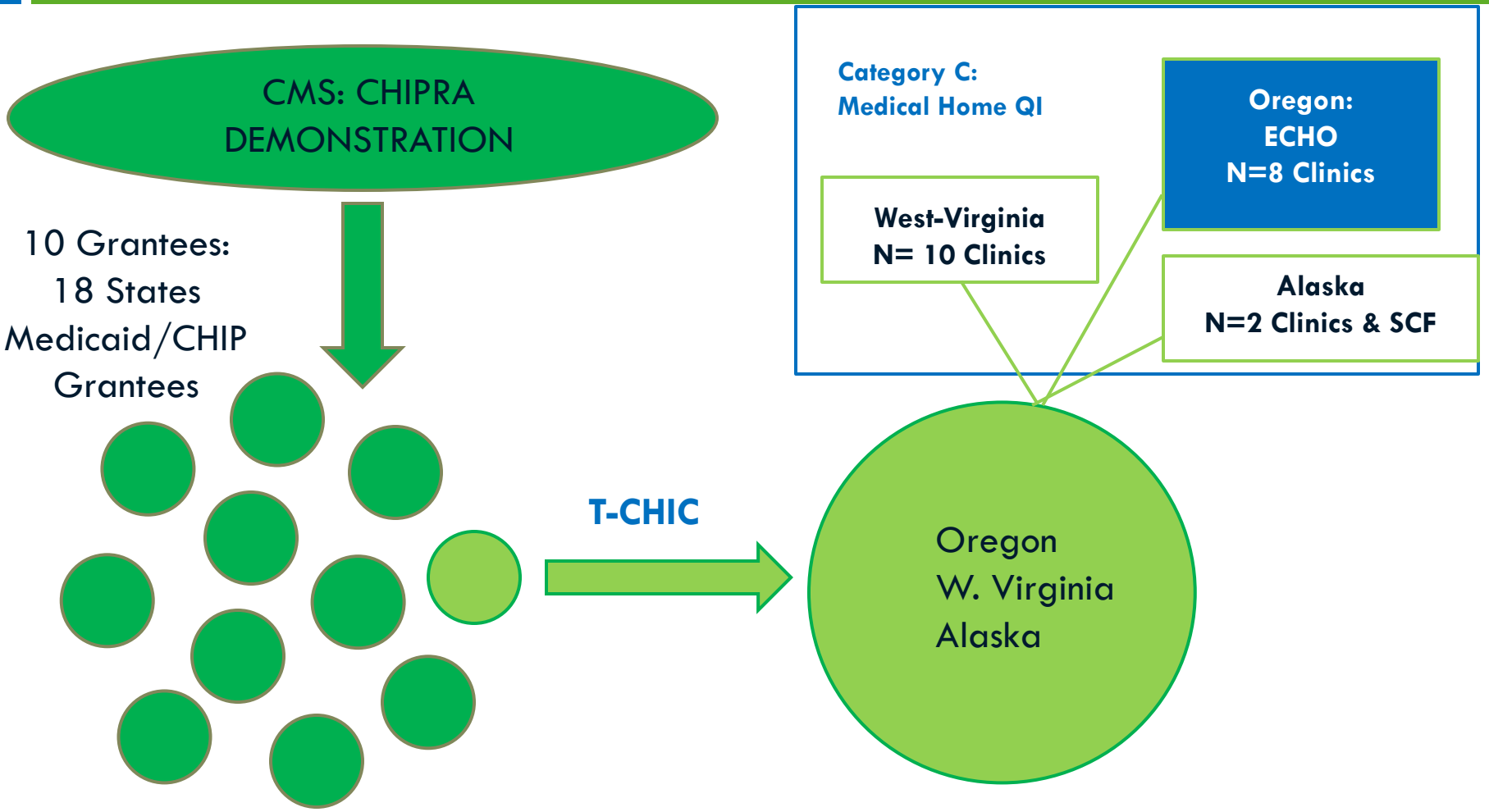


CHIPRA 2009

States emphasizing PCMH



Where ECHO Fits

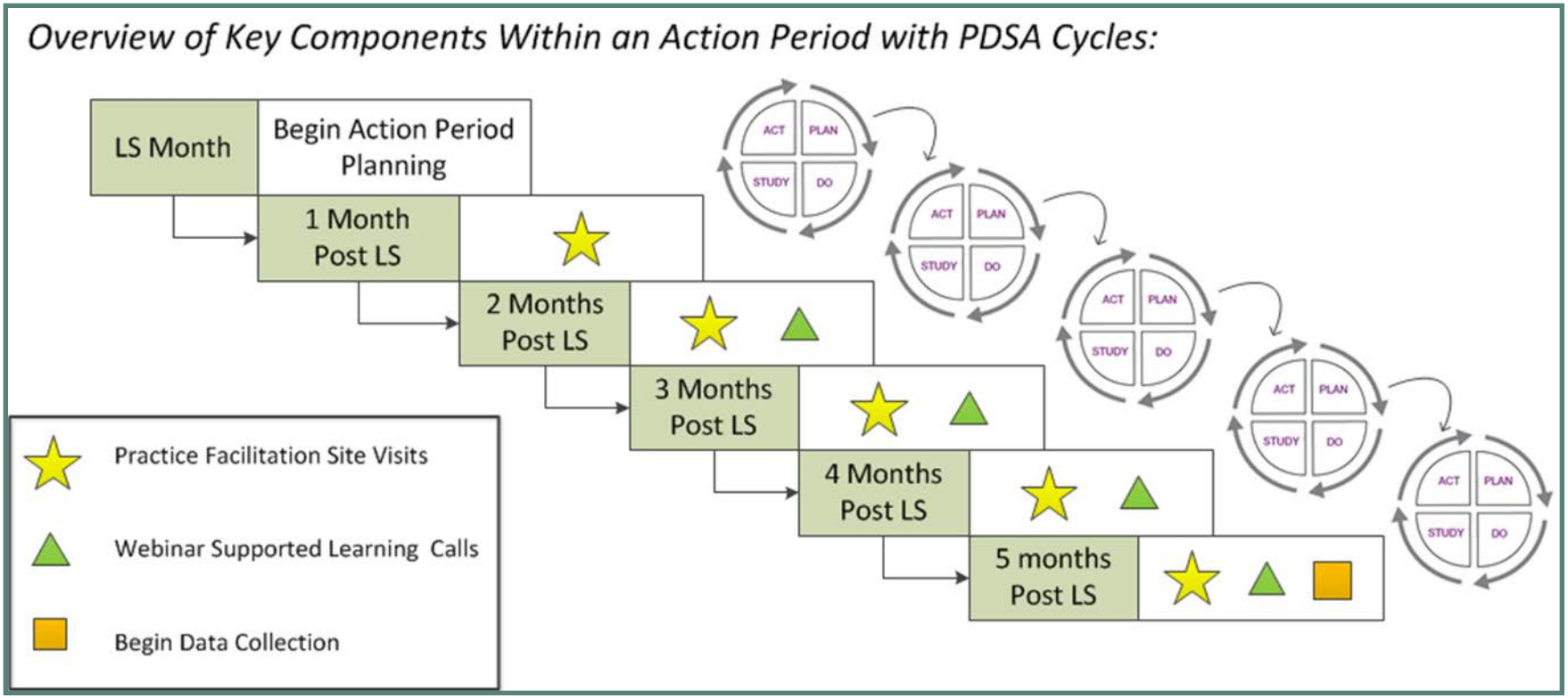


What is the Enhancing Child Health in Oregon (ECHO) Learning Collaborative?

RJ Gillespie,
Oregon Pediatric Improvement Partnership (OPIP)

Key components of ECHO's Learning Collaborative & Curriculum

- Public / private stakeholder engagement in planning structure and curriculum
- Partnership with OHA to inform policy change
- Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) as critical teaching partner
- 5 full-day, themed learning sessions over 2 years
  - Expert and patient keynotes.
  - Standardized evaluation data collection across sites, shared and used to inform QI efforts.
- Action period support and facilitation following learning sessions
  - Monthly webinars, site visits, email support.



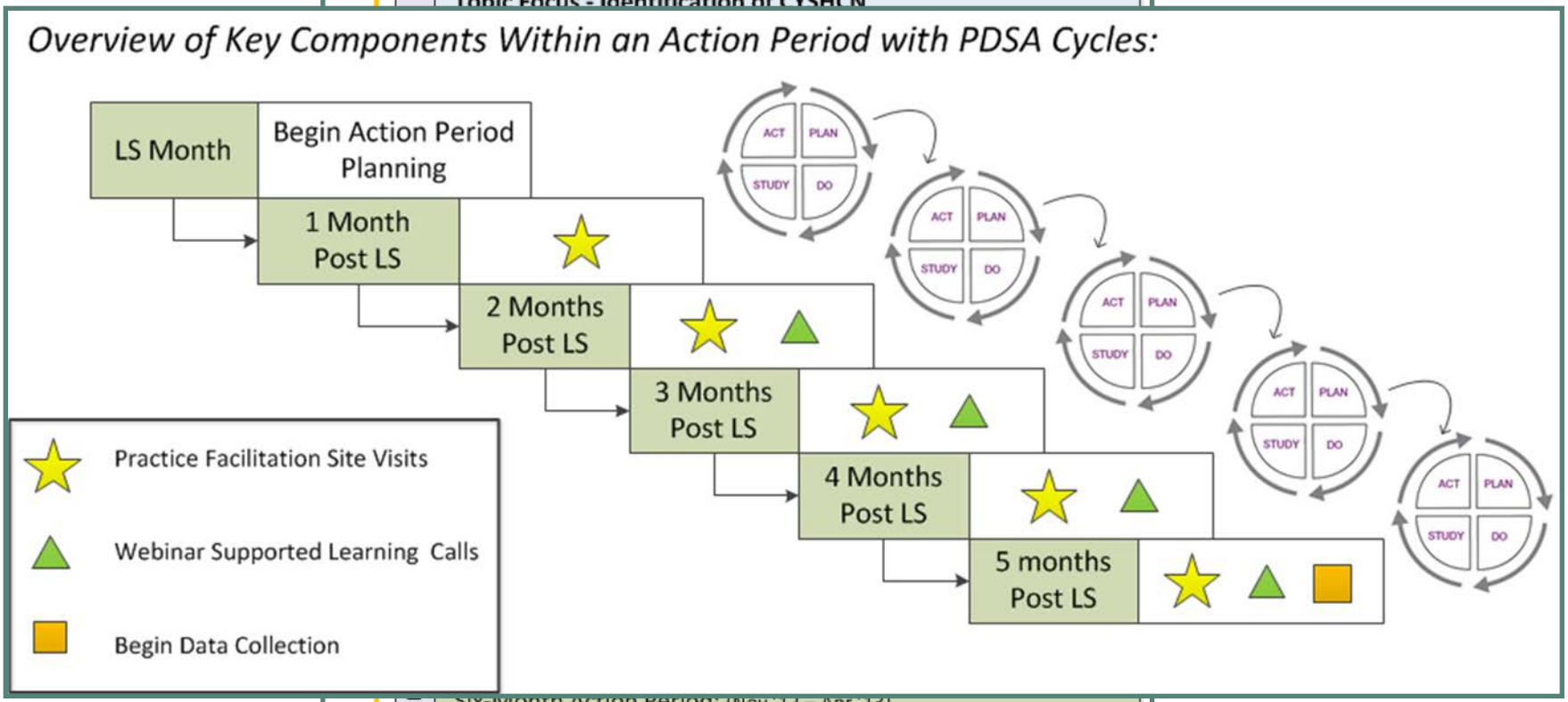
Evaluation Data: Used to Inform and Evaluate ECHO LC

- **Office Reports of Systems & Processes**
  - Patient Centered Primary Care Home (PCPCH) certification and accreditation
  - NCQA Patient Centered Medical Home (NCQA PCMH)™ 2011
  - Medical Home Index-Revised Short Form (MHI-RSF)©
- **Patient Experience of Care**
  - CAHPS® CG PCMH
- **Participant Experience**
  - Surveys of participants before and after each in-person Learning Session
  - After the project ended, strategic interviews

ELEMENTS OF THE ECHO LEARNING COLLABORATIVE

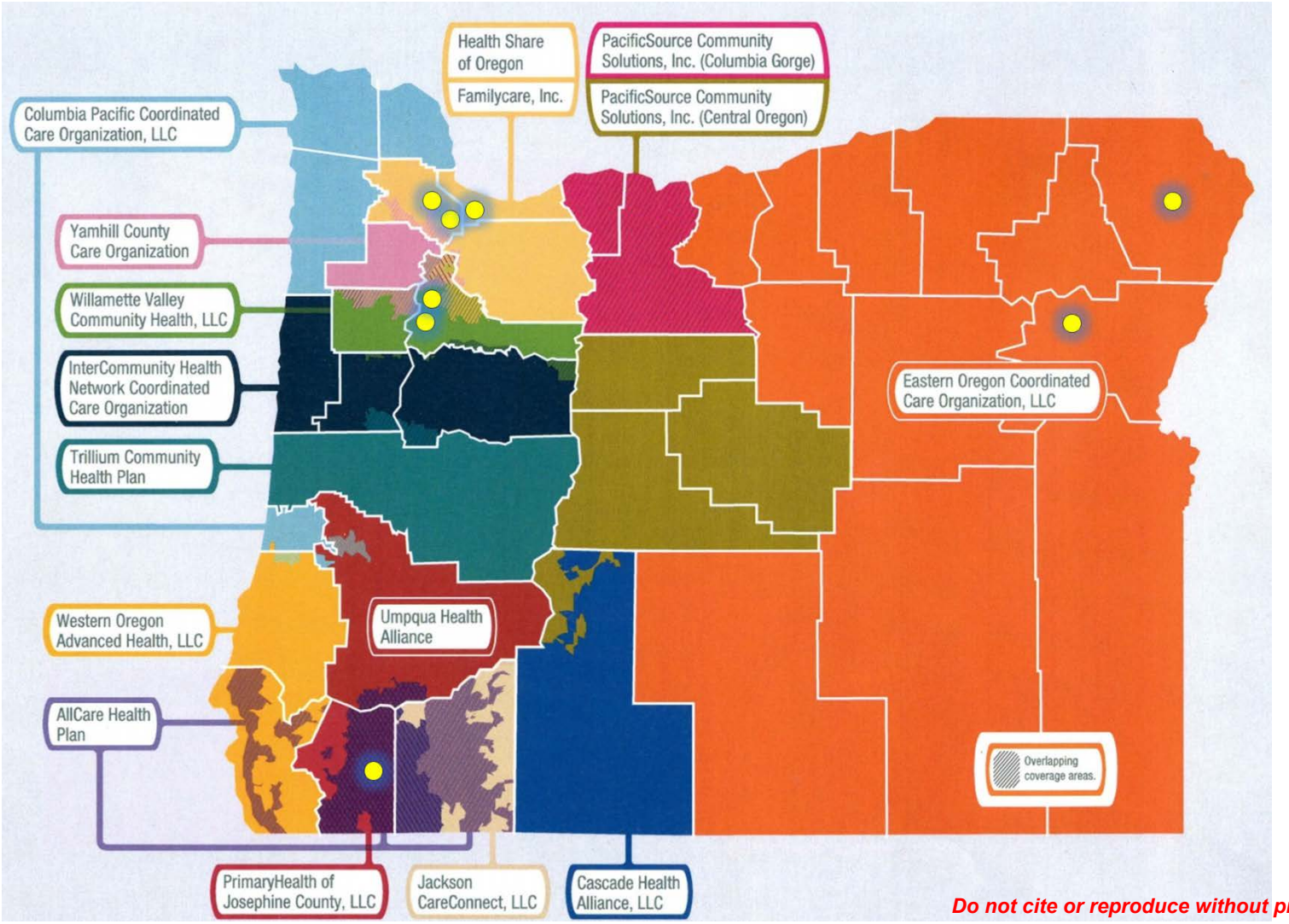
	Data Collection #1: **Fall 2011 Baseline Data**
	Learning Session #1: (November '11) **Topic Focus - Identification of CYSHCN**

Overview of Key Components Within an Action Period with PDSA Cycles:



	Six-Month Action Period: (Nov '12 – Apr '13) **Practice-Based QI on Behavioral Health Screening**
Spring 2013	Data Collection #4: **Spring 2013 Evaluation Data**
	Learning Session #4: (May '13) **Topic Focus - Family Professional Partnerships**
	Six-Month Action Period: (May '13 – Oct '13) **Practice-Based QI on Family and Patient Engagement**
Fall 2013	Data Collection #5: **Fall 2013 Evaluation Data**
	Final Learning Session #5: (November '13) **Topic Focus - Sustainability & Spread**
Spring 2014	Data Collection #6: **Final Spring 2014 Evaluation Data** (May '14 – Six months after Final Learning Session)

ECHO Practice Sites



Intentional Recruitment to Inform Impact and Spread

- Eight private practices
  - Over the course of the project, one practice was bought out by a large health system
- 3 rural, 3 suburban, 2 urban
- Serve over 100,000 patients
- Improvements for all patients, not just publicly insured.
  - Range of publicly insured 10% to 74%

What We Learned / ECHO Outcomes:

What Changed for Participating Practices and their Patients?

Highlight of Transformation in the ECHO Practices

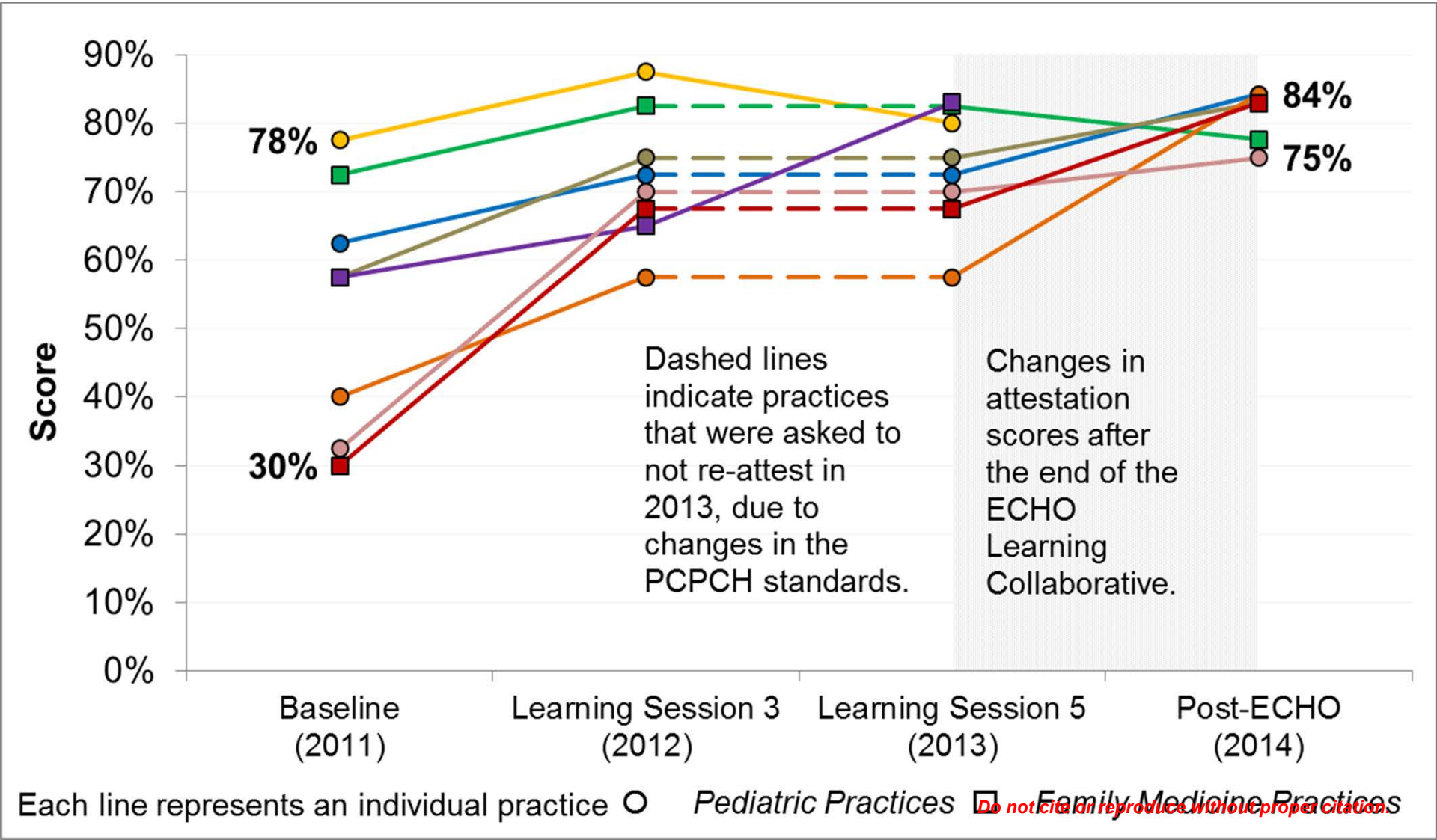
1. **The numbers and the stories behind the data**
   Colleen Reuland, OPIP

2. **Reflections from participating providers**
   Video Vignette

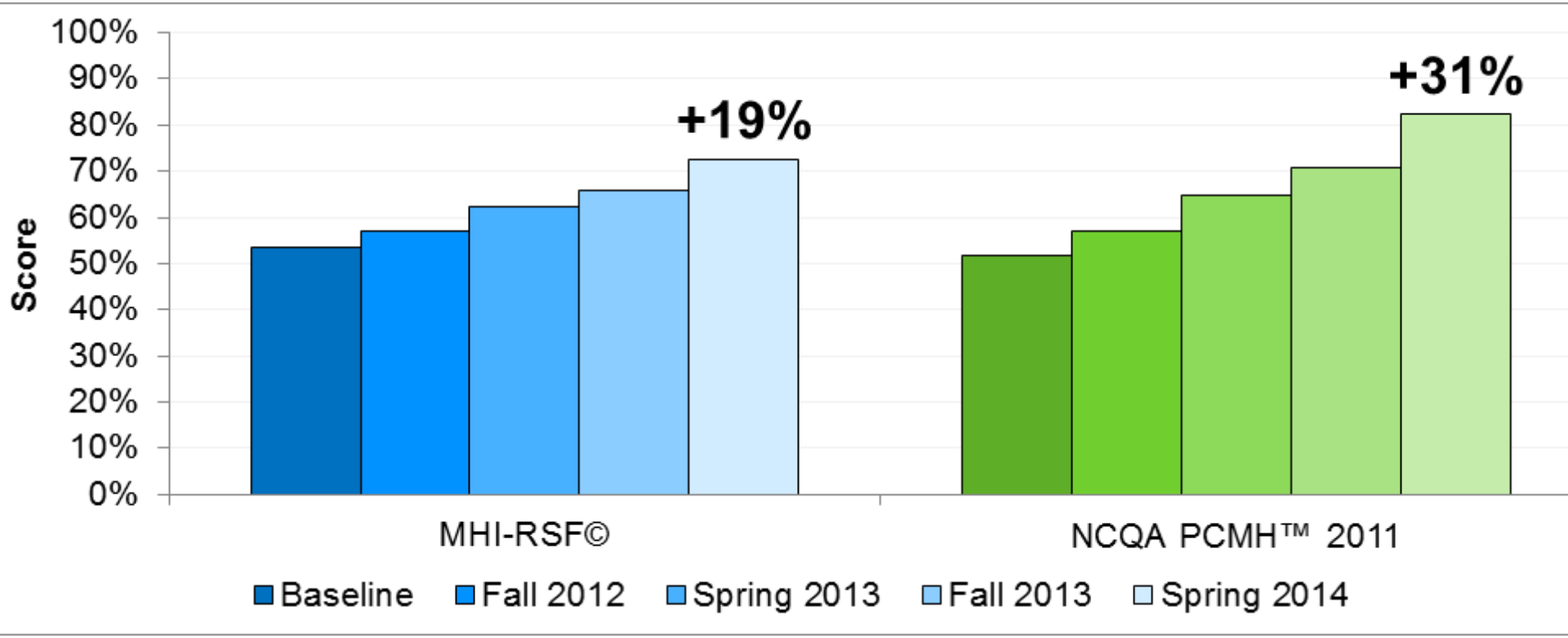
3. **A parent perspective**
   Alicia DeLashmutt, OPIP Parent Partner

4. **Reflections from the practices: What helped and what got in the way**
   L.J. Fagnan, Oregon Rural Practice Based Research Network (ORPRN)

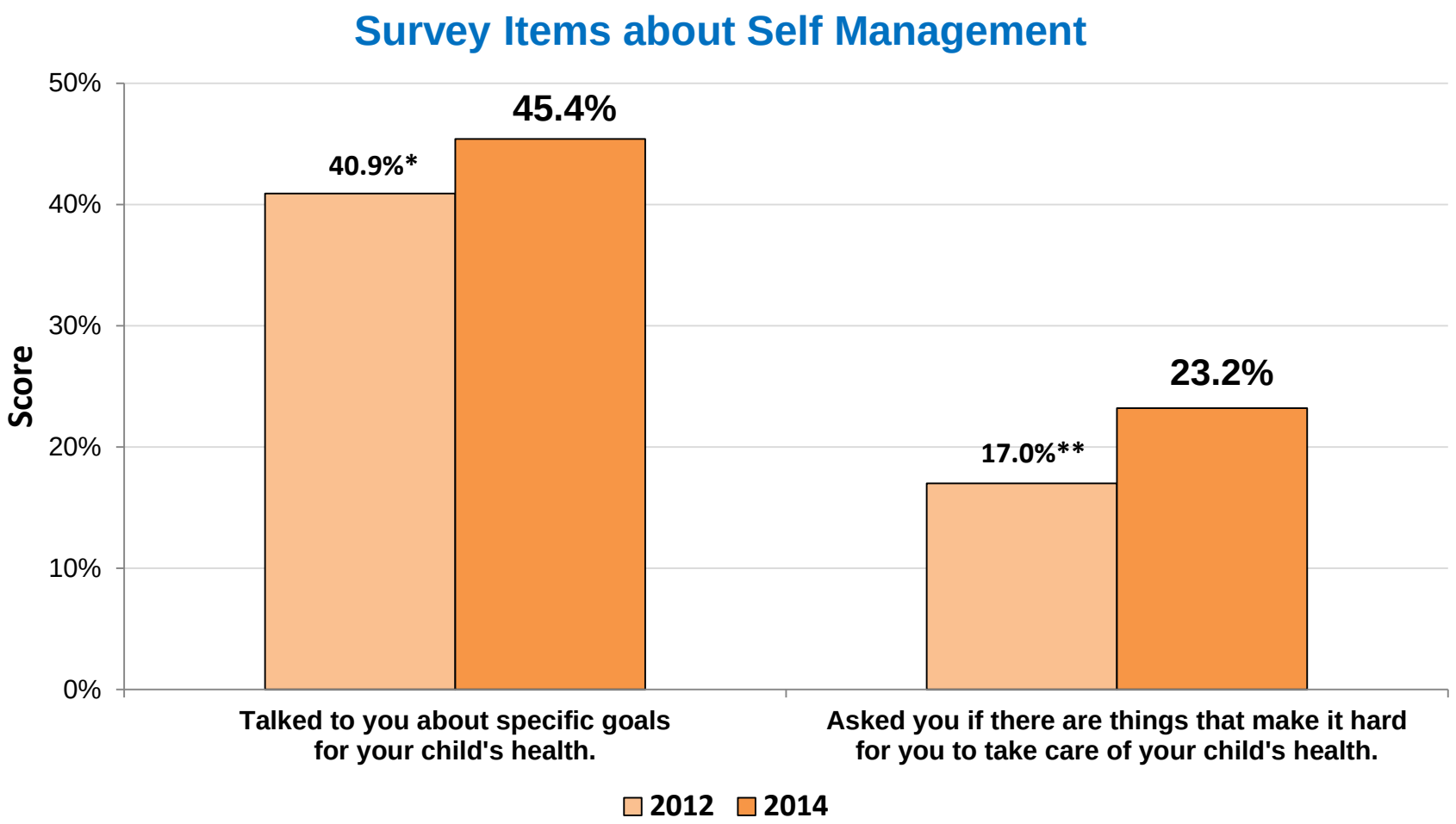
All ECHO Practices Achieved Tier 3 Status



Medical Home Transformation Achieved by ECHO Sites

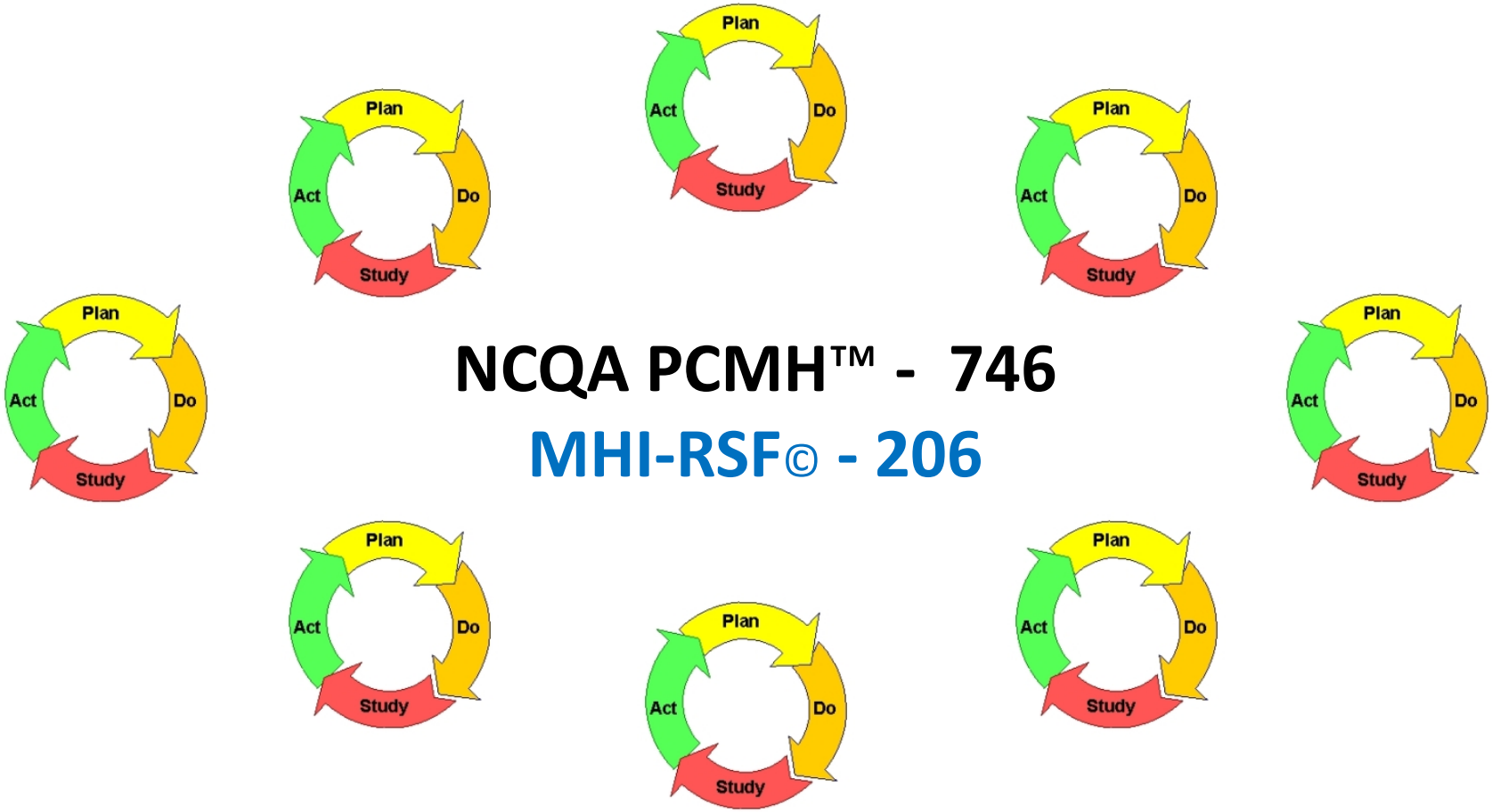


Improvements in Patient Experience of Care



ECHO practices CAHPS® Clinician & Group PCMH Rates 2012 and 2014 (excluding Siskiyou Pediatrics)
**p=0.001 **p=0.009*

Number of Individual Processes Improved Across the Practices



NCQA PCMH™ - 746

MHI-RSF© - 206

Key Processes Improved by the Majority of ECHO Practices

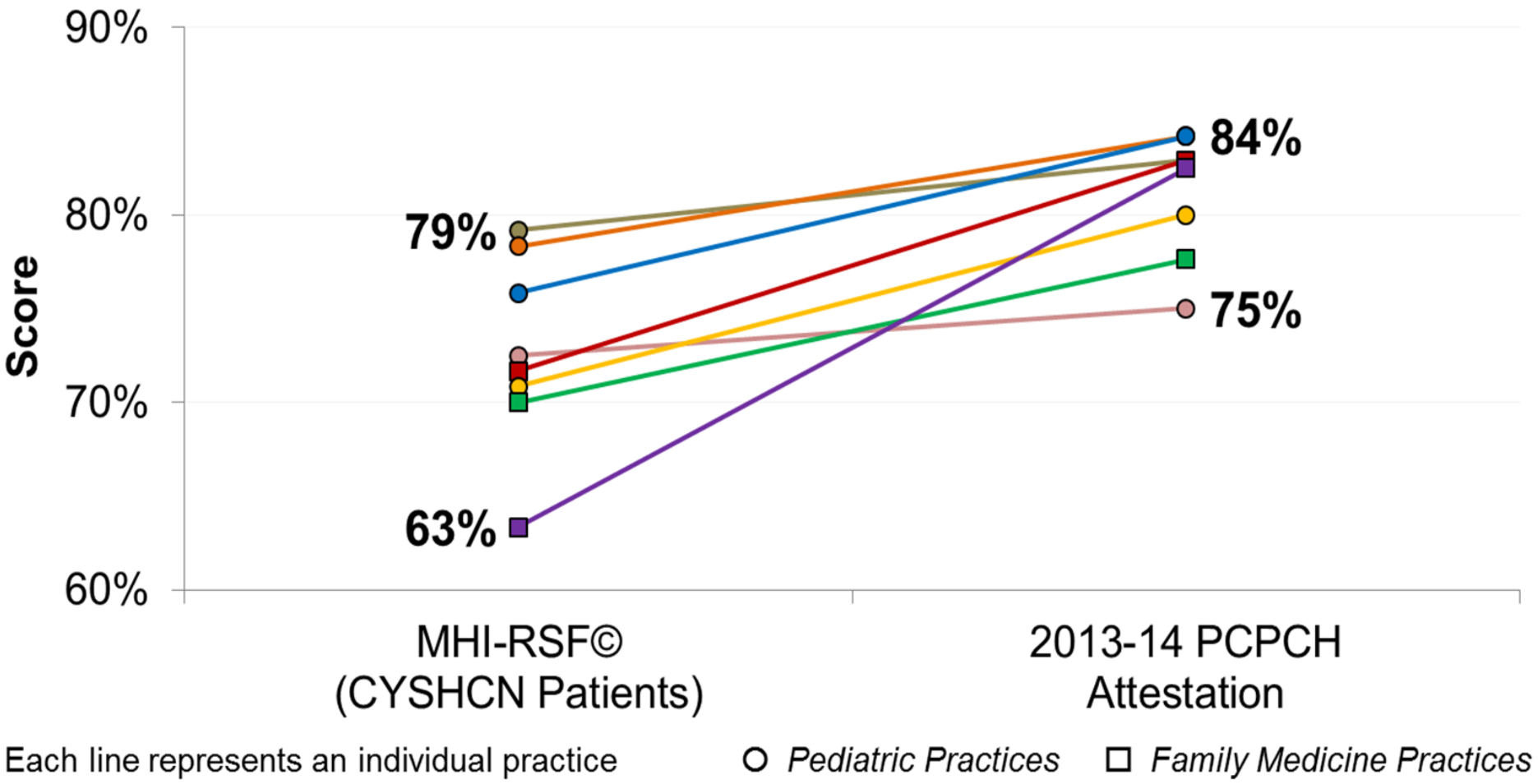
ENHANCED MEDICAL HOME ACROSS THE PRACTICE

1. Team-Based Care
2. Meaningful Use of Surveys
3. Population management

IMPROVEMENTS FOR CYSHCN

1. Mission of the Practice
2. CYSHCN Family Feedback
3. Care Coordination/ Role Definition for CYSHCN
4. CYSHCN Family Involvement

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



After Two Years - What Remained as Opportunities for Improvement for All Eight Practices

- **Spread of care plans, documentation and tracking of self-management goals**
- **Cooperative management between PCPs and specialists for CYSHCN**
- **Adolescent transition**
  - Collaborate with the family to develop written care plan for transition from pediatric to adult care
  - For adolescents with special health care needs, ensure their specific needs are addressed

The Story Behind the Data:

How Did Care Transform to Better Meet the Triple Aim and Priority Goals for the State?

Care Coordination & Connection to Kindergarten Readiness

ECHO Strategies to Support Transformation Around Care Coordination

- **Care Coordination: Focus of 2nd In-Person Learning Session (May '12)**
  - Keynote by Oregon Center for Children with Special Health Needs (OCCYSHN) *AND* three Parents of CYSHCN
  - Focused on functions of care coordination
  - Highlighted importance of understanding context of the family and complexity scales

- **Webinar-supported Training Calls and Supports**
  - Teamness
  - Shared Care Plans
  - Referral Tracking and Management
  - Patient Engagement in Quality Improvement

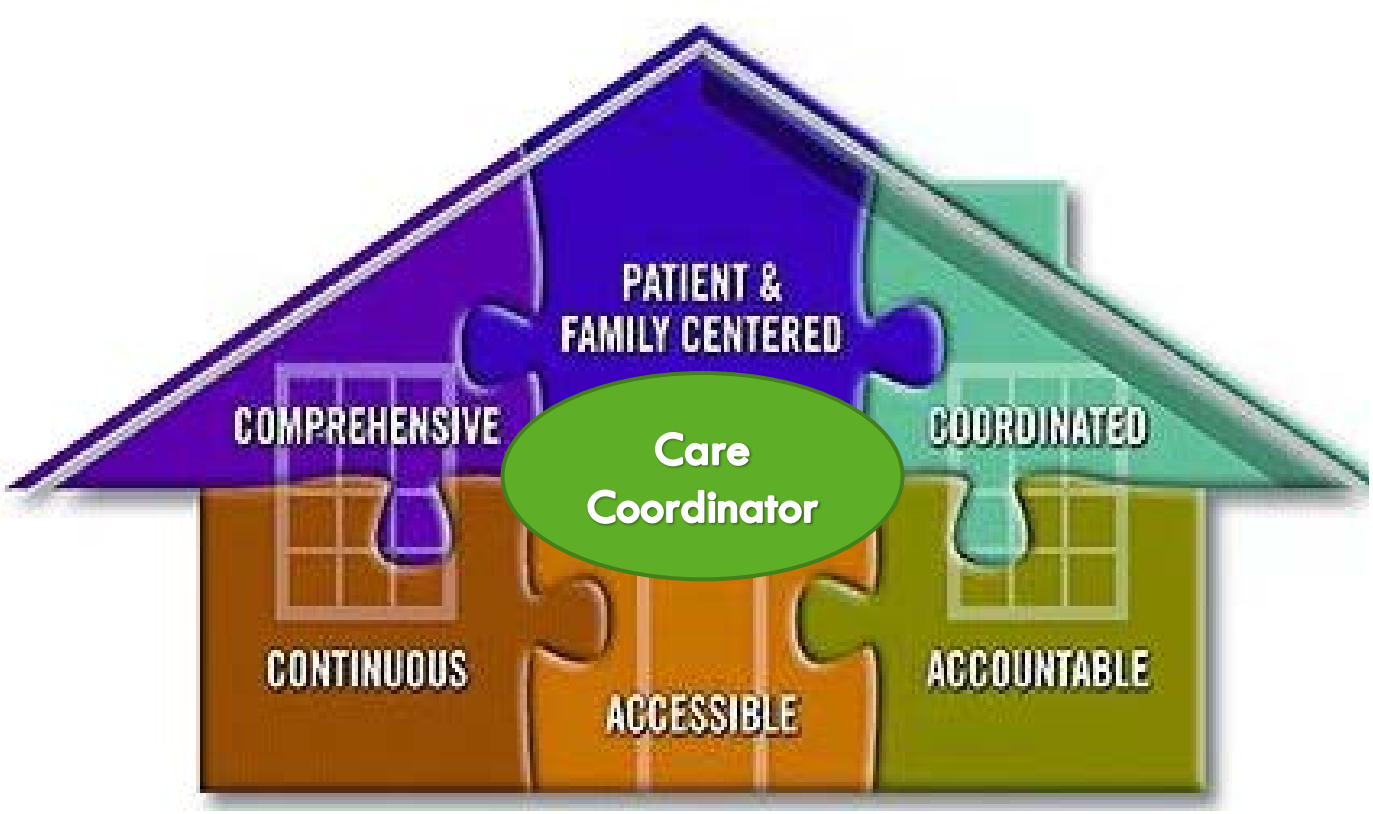
- **Family & Professional Partnerships: Focus of 4th In-Person Learning Session (May '13)**
  - Tools and strategies to partner with patients and their families
  - Family-centered methods to partner around share care plans
  - Highlight of community based providers

Internally Supported Care Coordinators in the ECHO Practices

Practice	Fall 2011	Spring 2014
Childhood Health	Yes	Yes
St. Luke's EOMA	Yes	Yes
Family Medical Group	**No** →	**Yes**
Hillsboro Pediatrics	**No** →	**Yes**
Siskiyou Pediatrics	No	No
The Children's Clinic	**No** →	**Yes**
Winding Waters	Yes	Yes
Woodburn Pediatrics	**No** →	**Yes**

- During the project <u>all eight practices</u> hired a care coordinator.
- As of **Spring 2014** (*6 months after the end of ECHO*), **7 of 8** practices have been able to **maintain their care coordinator positions**.

Care Coordinators: The "Node" within Practices and Teams



Example:
Resources that **Care Coordinators** from an ECHO practice may connect with ***within*** their own practice:

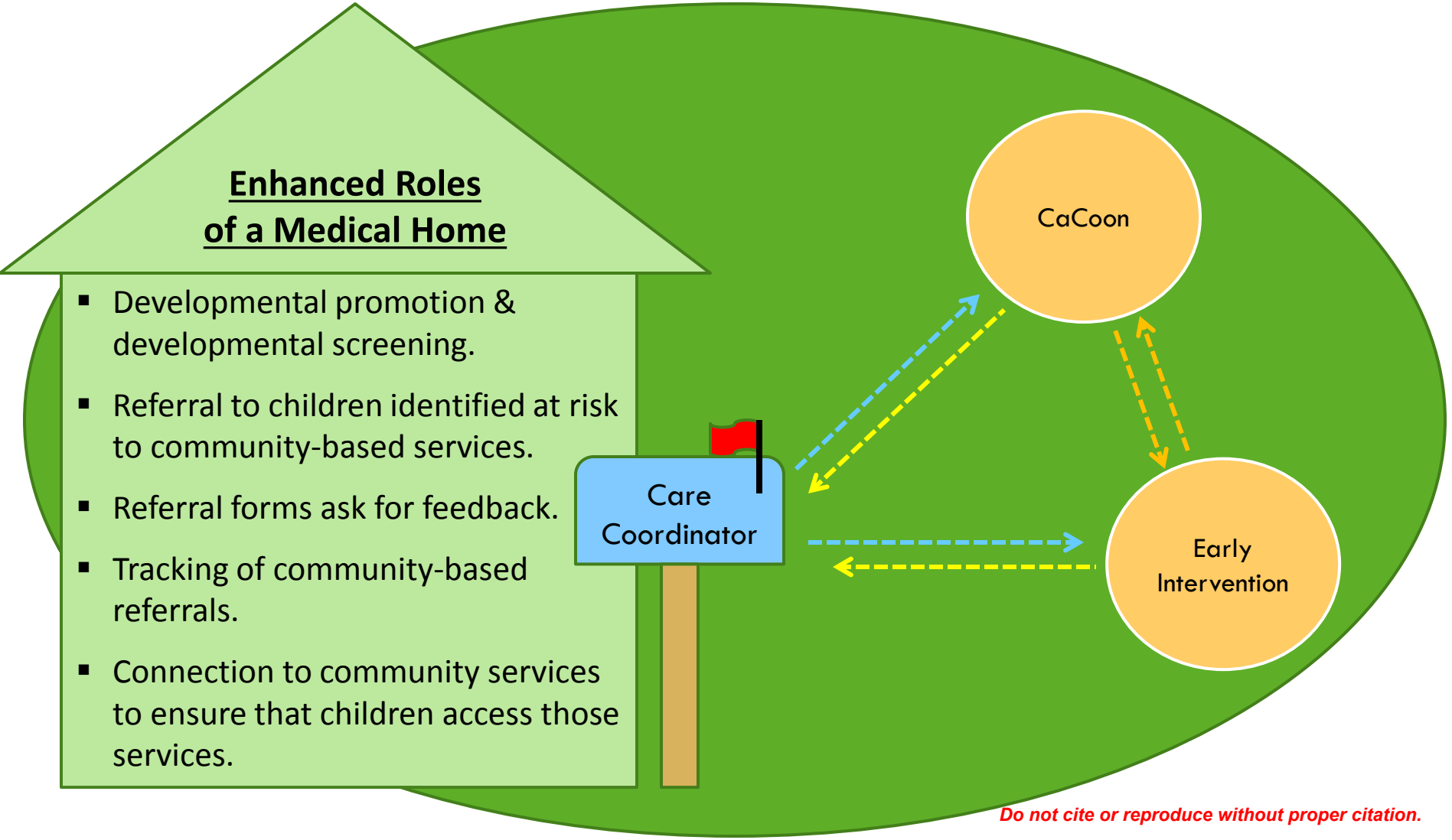
- Primary Care Provider
- Nurse / Medical Assistant
- Behaviorist
- Dietician
- Social Worker
- Billing & Insurance
- Administration
- Front Desk Staff
- Lab Tech

Medical Homes Create "Nodes" within Practices:
Critical to Effective Connection to Community-Based Resources

Community The Child's Family Lives In

- Marion County DD Services
- CaCoon
- County Health Initiative Project
- YMCA
- Rascal Rodeo
- Swindells
- Oregon Childhood Development Coalition
- Woodburn City of Salem/ Woodburn Aquatics Center
- Creating Opportunities
- Family to Family
- Special Needs Coalition in Marion/Polk County
- Love Inc.
- Early Intervention
- Woodburn Fostering Hope

Power of a Medical Home in Achieving the Goal of Kindergarten Readiness: Ensuring At-Risk Children Receive Services



Patient (Child & Family) Partnership & Engagement and Connection to CAHPS® Incentive Metrics

Strategies for Partnership with Patients Focused on within ECHO

1. **Parents as keynote speakers at every Learning Session**
2. **Parents on the project team**
3. **Emphasis in the ECHO Learning Curriculum - Trainings and Coaching on:**
   - Parents on QI teams
   - Parental input on specific change strategies & tools
     - *Examples*: Medical home agreements, shared care plans, and referral tracking processes
   - Focus groups – episodic
   - Parent advisory groups or having a parent role on medical home advisory groups
   - Meaningful use of patient experience of care surveys

Power of Patient-Experience of Care Data in a Patient-Centered Medical Home QI Project

NCQA PCMH™

- Enhance Access and Continuity
- Identify and Manage Patient Populations
- Plan and Manage Care
- Provide Self-Care Support and Community Resources
- Track and Coordinate Care
- Measure and Improve Performance

MHI-RSF©

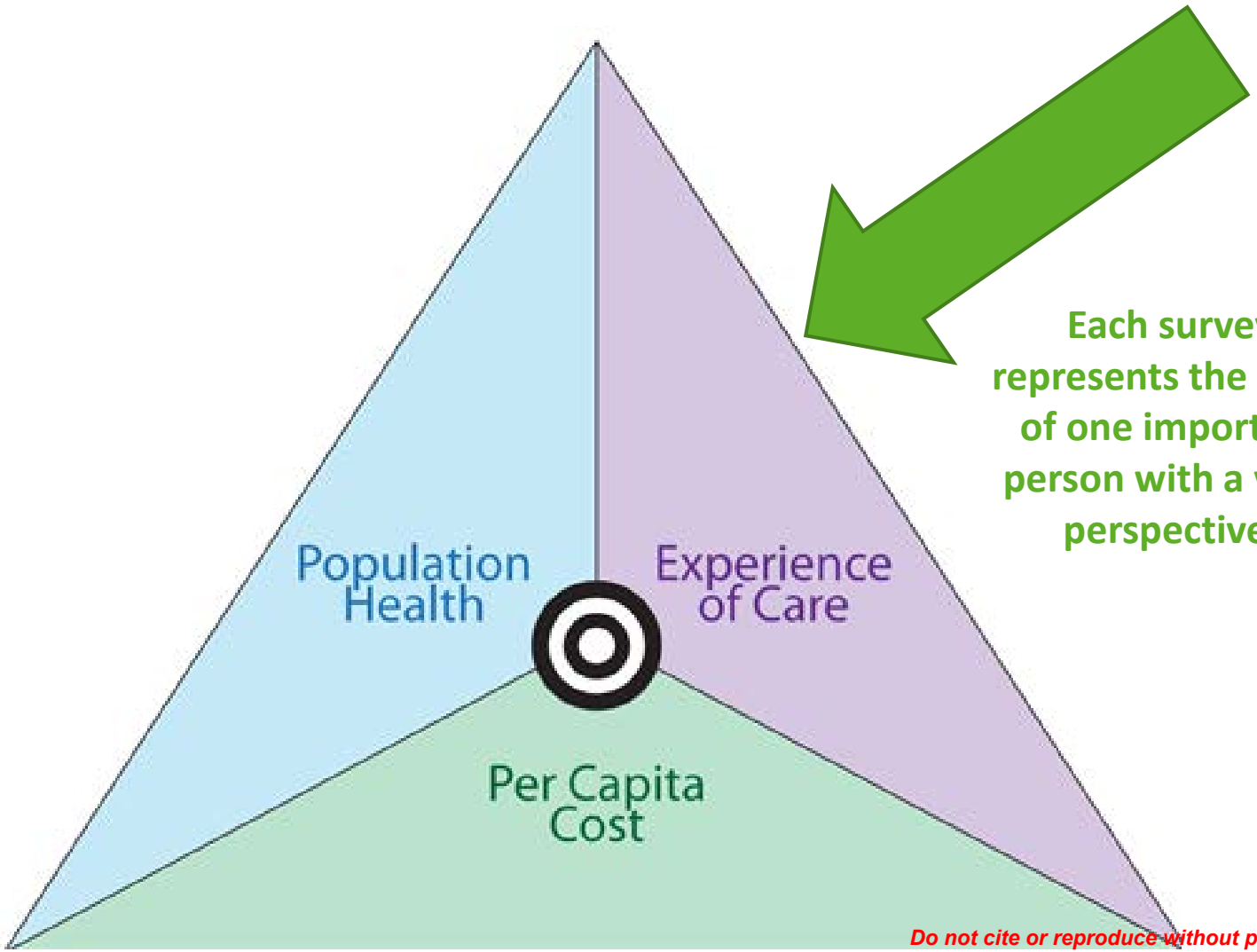
(specific to CYSHCN)

- Organizational Capacity
- Chronic Condition Management
- Care Coordination
- Community Outreach
- Data Management
- Quality Improvement / Change

CAHPS® CG PCMH

- Access
- Communication
- Self-Management Support (T-CHIC Added)
- Care Coordination (T-CHIC Added)
- Office Staff
- Shared Decision Making (**Adult**)
- Adult Behavior (**Adult**)
- Comprehensiveness - Child Development (**Child**)
- Comprehensiveness - Child Prevention (**Child**)
- **T-CHIC Variables of Great Value to the Practices**
  - CYSHCN Screener

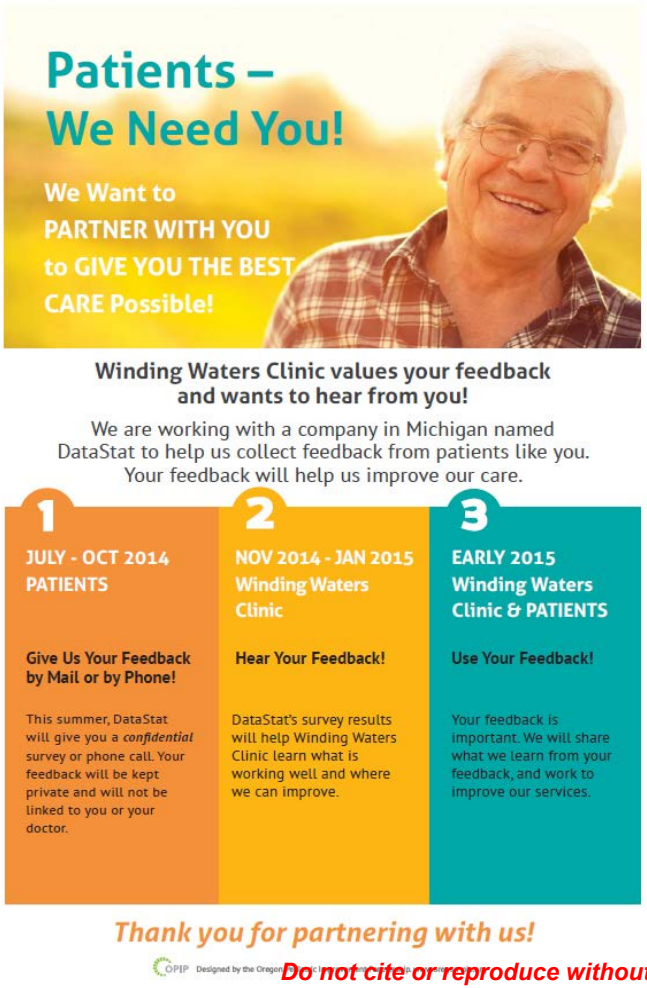
Goal of Health Reform: Achieve the Triple Aim



Each survey represents the voice of one important person with a valid perspective.

Materials to Engage Patients in the CAHPS® CG PCMH

POSTERS to Educate Patients about the Survey:



Ability to Slice and Dice the CAHPS® CG PCMH Data: Meaningful Data on Disparities to Guide QI

- **Able to analyze data by the following groups to assess for disparities**
  - Ethnicity
  - Race
  - Language survey completed in
  - Age of patient
  - Health status, mental health status
  - Parental demographic factors (e.g. education)
- **Population data on Children & Youth with Special Health Care Needs**
  - Rates of CYSHCN
  - Types of health care needs they experience
  - Stratified the quality of care findings by CYSHCN

"AHA" Moments for Practices Based on CAHPS® CG PCMH Data

- **Systems and processes don't always yield the intended consequences for patients**
  - Access domain findings were surprising to a number of practices, despite having "open access"
  - Many practices were doing well *overall*, but found significant disparities in quality domains by child and respondent characteristics
- **Significant variations by practice and practice characteristics**
- **Nearly all practices needed improvement in the domain of Self-Management**
- **Large number of practices needed improvements in the quality domains related to Child Prevention and Child Development**
  - Practices that scored well had robust, comprehensive templates built into the EMR

Parents, We Heard You!

A year ago, we sent out surveys to learn how we are doing with the care we provide. We want to say *Thank You*.

We received 52 surveys!

Here is what we learned from our Woodburn families:

Areas of Excellence

What Is Going Well

Getting Care When You Need It
9 out of 10 parents said they usually or always got needed care.

Providers at Woodburn Listen
9 out of 10 parents said their providers usually or always listen carefully to them.

Opportunities

What We Can Do Better

Only 2 out of 5 parents said that someone talked to to them about *barriers and goals for their child's health*.

Only 2 out of 5 parents said their provider gave them information about how to *keep their child from getting injured*.

Using Your Feedback

Using Your Feedback To Improve

We are working on a project to partner with our patients and set health goals:

* We will be focusing on how we can develop care plans that fit your child's needs.
* These care plans will help track progress on health goals.

Our Improvement Team:

* A team at Woodburn Pediatrics is working on this project.
* Your opinion is valuable!

Let us know if you want to JOIN OUR IMPROVEMENT TEAM @ 503-981-5348

THANK YOU FOR PARTNERING WITH US TO GIVE THE BEST CARE POSSIBLE

The Children's Clinic Portland
October 9

We heard you!
In the Fall of 2012, The Children's Clinic partnered with the state Medicaid in running a patient survey called the CAHPS (Consumer Assessment of Healthcare Provider Services). The kind of information that we get from the survey helps us to improve the care that we give, so we appreciate everyone who filled out the survey.
We've been looking at the survey results for several months to see where we are doing well, and where we need to do better. From what you've told us, we're doing well with our customer service (our front desk staff is great!) and are doing pretty well with talking through your child's development.
One of the things that we hope to do better in after the surveys is what's called "self management support". The idea is that you come to the visit with your pediatrician with goals for their own health. You also come with things that might make it harder to follow through with doing the things that we suggest during the visit. Part of our job as health care providers is to understand both of these things – your goals and your barriers to being healthier – and to help you figure out how to achieve your goals and overcome your barriers. As pediatricians, we have things that we want to teach you at the visits, but we hope to make our time together more of a partnership.
If you didn't get a survey (the sample was random, so not everyone was asked!), we still love to hear from you about how we are doing. You can fill out a comment card during your visit, or give feedback through our website. We hope to run the survey again next year, so stay tuned!

Integrating Behavioral Health Screening into Primary Care & Connection to Related Incentive Metrics

Strategies Used within ECHO Focused on Integration of Behavioral Health into Primary Care

- **Integrating Behavioral and Mental Health into Primary Care: Focus of the November '12 Learning Session**
  - Parent keynote on experience with fragmentation
  - Models of integration, co-location, and readiness assessment
  - Practice tools and resources to enhance screening
    - Spotlight on strength- and risk-based screening tools to use with adolescents
- **Webinar-supported Training Calls and Supports**
  - Screening for maternal depression and available community resources
  - Trauma informed patient-centered medical home for children exposed to violence

ECHO Practices Enhancing the Quality of Adolescent Well-Visits

- **All eight practices implemented a broad strength- and risk-based screening tool as part of their adolescent well-visits (Incentive Metric)**
  - Majority are using a tool developed by one of the sites and shared with the others
  - Tool included depression and substance abuse screening (2015 Incentive Metrics)
- **Most practices have hired a behaviorist or have connected with behavioral heath specialists to address issues that arise BUT experiencing significant barriers**
  - Issues with lack of resources for referrals for adolescents, lack of communication back to the practices after referral
- **Not using the codes in the incentive metrics -for adolescents- as currently specified**
  - Some of the codes are G codes (adults only)
  - Worry about violating adolescents' rights to confidential care

Practice Investment

Highlight of Resources Invested:

- Time away from clinic to attend meetings:
  - 3-5 Team members attended LS
  - Monthly meetings with facilitator
  - QI team meetings in-between
- Parent partners
  - Parent partners on the QI team
  - Patient involvement on medical home advisory committee
- Care Coordinators
- Co-located services

Alternative Payment Experienced…So Far

- Most payors not providing enhanced payments based on Tier level
- Handful of payors providing PMPM;
  - Most common one is associated with the state PEBB contract and paid semi-annually
  - One practice noted higher PMPM rates with a single CCO <u>with metrics</u> tied to care coordination and incentive metrics

Examples of Other Incentives:

- Now eligible for QI programs/grants because they are medical home

Enough of Us Talking: Let's Hear from the Practices

Video Vignette

A Parent Perspective of ECHO:

Alicia DeLashmutt, OPIP Parent Partner

Evolution as a Team Member

OPIP
Oregon Pediatric Improvement Partnership

Glossary & Acronym List

- 211 – A parent/family helpline, and is operational in various regions throughout the state.
- AAP – American Academy of Pediatrics is an organization dedicated to the health and well-being of infants, children, adolescents, and young adults.
- Aim Statement – A written, measurable, and time-sensitive description of the accomplishments the Team expects to make from its improvement efforts.
- ASO – Autism Society of Oregon.
- Attribute vs. Standard (PCPCH) – The Core Attributes and Standards are intended to establish a common framework for understanding the structure and functions of a PCPCH from the patient and family perspective. Each of the six core *Attributes* (Access to Care, Accountability, Comprehensive Whole Person Care, Continuity, Coordination and Integration, and Person and Family Centered Care) are associated with multiple *Standards* that describe in more detail the care delivered by a PCPCH.
- BTS – Breakthrough Series. The IHI model for quality improvement learning collaborative
- CAHMI – Child and Adolescent Health Measurement Initiative. A national initiative that works to ensure that children, youth, and families are at the center of quality measurement and improvement efforts in order to advance a high quality consumer-centered health care system.
- CAHPS – Consumer Assessment of Healthcare Providers and Systems. CAHPS is a multi-year initiative of the Agency for Healthcare Research & Quality (AHRQ) to support the assessment of consumers' experiences with healthcare. Info on CAHPS: http://www.cahps.ahrq.gov/About-CAHPS/CAHPS-Program.aspx
- CAHPS CG – Consumer Assessment of Healthcare Providers and Systems, Clinician & Group. These Clinician & Group surveys include standardized questionnaires and optional supplemental items for adults and children, and ask patients about their recent experiences with clinicians and their staff. Info on CAHPS CG: https://cahps.ahrq.gov/surveys-guidance/cg/index.html
- CAHPS CG PCMH – Consumer Assessment of Healthcare Providers and Systems, Clinician & Group, Patient-Centered Medical Home. This is the expended version of the CAHPS CG 12-month survey that incorporates the CAHPS Patient-Centered Medical Home Item Set. It is especially useful for physician practices that have adopted features of a PCMH. Info on CAHPS CG PCMH can be found at: https://cahps.ahrq.gov/surveys-guidance/cg/pcmh/index.html
- Capitation – A method of paying health care service providers (e.g. physicians or nurse practitioners) a set $$ amount for each enrolled person assigned to that physician or group of physicians, whether or not that person seeks care, per period of time.
- Care Coordination – Practice-based care coordination within the medical home is a direct, family/youth-centered, team oriented, outcomes-focused process, designed to:
  - Facilitate the provision of comprehensive health promotion and chronic condition care;
  - Ensure a locus of ongoing, proactive, planned care activities;

1 | Page

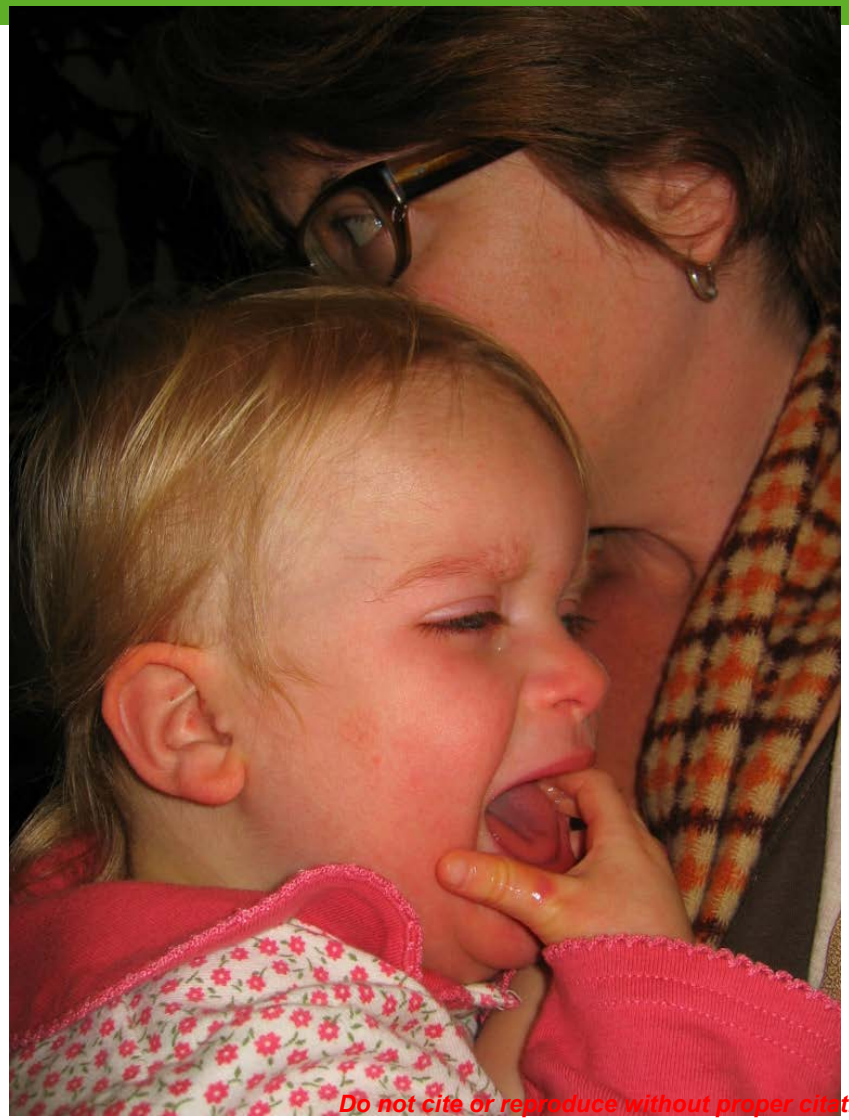
- Keynote speaker at a Learning Session
- Applied for the OPIP parent partner position
- Started with a steep learning curve- pages and pages of acronyms and terms!
- Began to feel more comfortable taking on project level roles
  - Attending meetings and monthly webinars with sites- always provided a reaction during or at the conclusion
  - Participate in practice-level planning sessions at Learning Sessions
- Eventually began assisting participating practices, through the review of policies, and other patient and parent facing documents

Evolution of Practices

- Novel concept- met with much hesitation!
  - Movement was slow at first
  - Always valued parents at learning session
  - Tendency was for sites to want to wait for a better time
  - Generally supportive, but not sure how to move forward
- Over time, sites began trying ways to incorporate and engage the parent/patient voice into quality efforts
- At the final Learning Session, sites identified this concept as one of the most valuable and transformative
  - While there is still a long way to go, and there are many opportunities for growth- **much changed over the course of the project!**

Now is as perfect as it's going to get...

- You see us at our most vulnerable.
- It's never going to be the perfect time (if we waited for our families to look perfect to you…)
- We have experience and expertise to share.
- It's about the children and families.



Take the plunge!

Reflections from the practices: What Helped and What Got in the Way

L.J. Fagnan, ORPRN

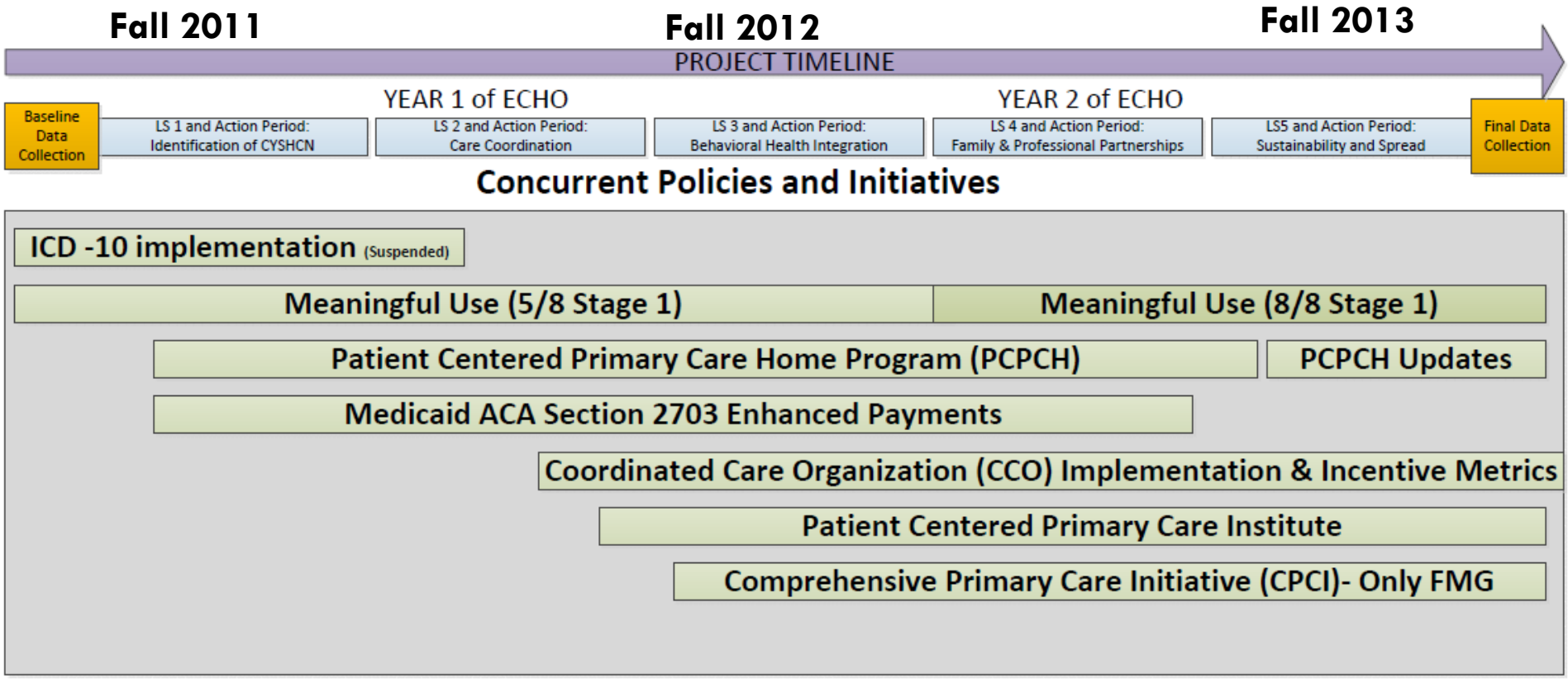
Enhanced Quality Improvement Structure

- 82% of participants reported being confident in **continuing transformation** work in their practice
  - Spring '14 follow-up data collected after the project ended showed **sustained improvements** in the practices
  - No significant declines in scores
- **Engaged the full practice staff** (leadership and office staff) on medical home. (7 out of 8)
  - Includes periodic clinic-wide communication
  - Spread of improvement efforts across the practice
- **Advisory committee of patients and families** for input and guidance on the quality strategy and improvement efforts within the practice (5 out of 8)

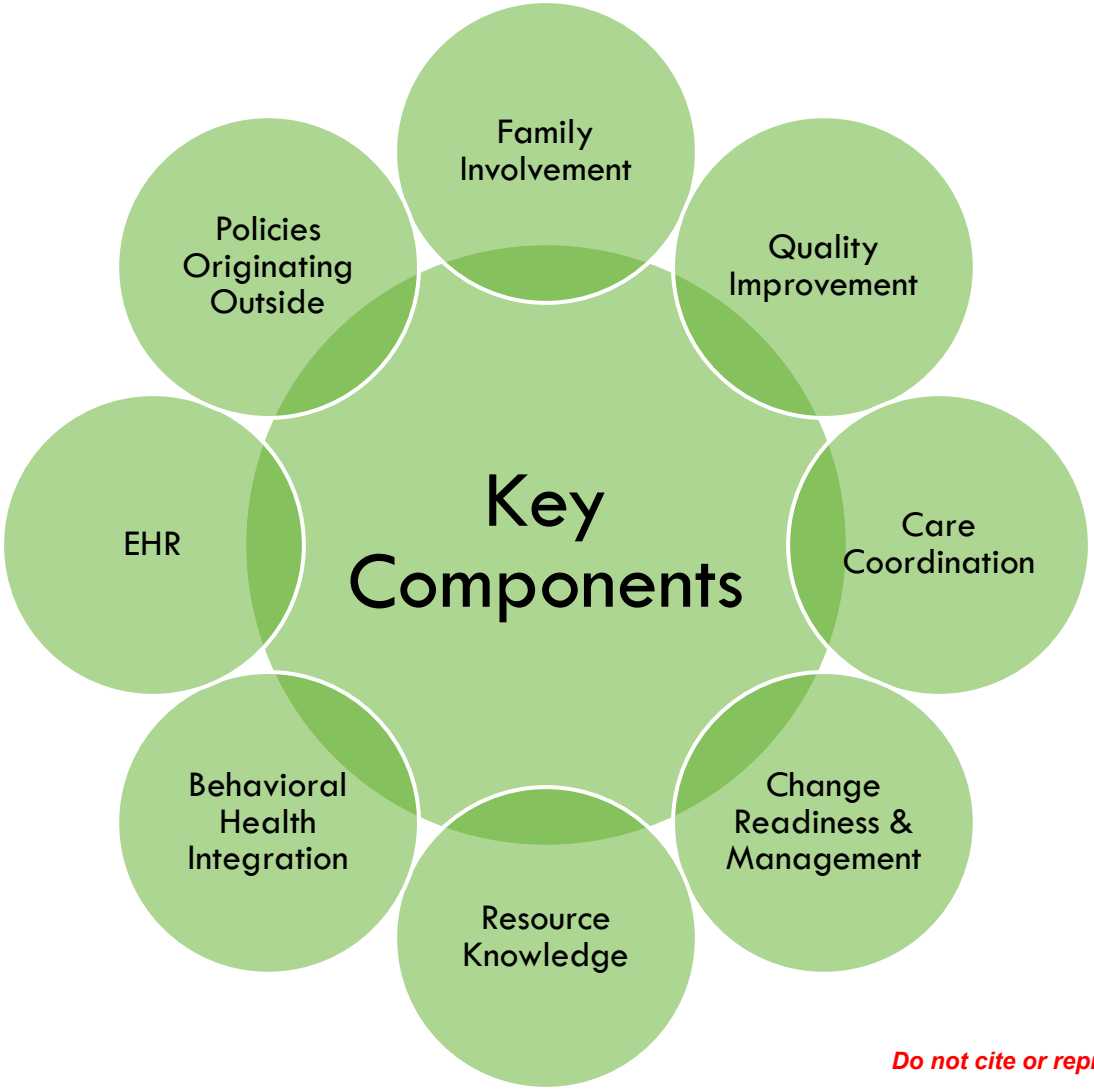
The Motivation

- **Extrinsic Motivators**
  - Public reporting
  - Management edicts
  - Financial incentives
- **Intrinsic Motivators**
  - Pride in performance
  - Concern for patients
  - Joy of work

Extrinsic Motivators / Barriers & Competing Factors for Practice Time to Work on Innovation



For Practices that Serve Children: What are the Key Components of Practice Change to Become an Effective Medical Home?



The Change Strategy

- Practices that transformed could "tell stories" about how they did it
  - They have a quality improvement process
  - They involved staff

- Teamwork stories:

  - **Medical assistant:** *"Makes us all feel like we are involved in the patient's care, not just doing the grunt work."*

  - **Physician champion:** *"Everybody is pitching in and working together…there is a sense of ownership, I believe from the whole clinic."*

Care Coordination - Practice Voices

- **Clinic 5:** *"The PCP does not have to initiate everything that the patient needs. They can also, you know, hand it over and say, 'this patient needs help from the community,' or 'they need help with this or that.'"*
- **Clinic 7:** *"…developing some of the care plans and templates, that was the most transformative."*
- **Clinic 7:** *"I think funding wise and staffing wise, it may be hard to continue with any kind of robust care coordination system, 'cause it wouldn't be affordable. We're understaffed with the RNs because we had some transition and people are in training. Trying to find enough time for care coordination is difficult. 'Cause the thing that is going to give first is going to end up being the care coordination."*

Care Coordination: The "Secret Sauce" to Practice Transformation

- Foundation built on team-based care, leadership, effective communication, population-based medication, shared care plans, and patient and family engagement
- Requires resources: Time, Personnel, Funding, and Tools
- Changes the practice culture: "The way we do things around here."
- The change is most likely *not* to survive *unless* adequate external support is provided

Lessons Learned for Dissemination & Spread

Oliver Droppers, OHA

ECHO Partnership & Reach

- **Federal and State Medicaid/CHIP Agencies**
  - CMS, AHRQ
  - State of Alaska
  - State of West Virginia
- **ECHO Learning Collaborative**
  - OPIP
  - ORPRN
  - OCCYSHN
  - Parents as key note speakers
  - Community-based experts
- **Oregon Health Authority**
  - Office for Health Policy and Research
  - Division of Medical Assistance
  - Health Analytics
- **ECHO Practices**
  - 8 urban and rural practices
  - Direct care to 100,000 + children across Oregon

Key Takeaways

- **Patient centered medical homes are transformational**
  - QI infrastructure and capacity – critical to establish *and* sustain high performing PCPCHs - requires sustained investment and technical assistance
  - Health IT is both a facilitator and a barrier to improving care of children
  - Serving children, including CYSHCN, requires special structures and processes in practices
  - Genuine patient engagement and partnership is transformative
  - Sustainability of foundational transformation change requires external resources

Key Takeaways

- **Learning Collaboratives work when key elements are present**
  - Data sharing; ensure actionability of the data for practices
  - Multi-faceted, learning curriculum
  - In-person, peer-to-peer learning sessions to foster "sense of community"
  - External practice facilitation
  - Meaningful engagement of OHA at learning sessions and as part of the community

- **Medical homes instrumental in coordinating community-based systems to help Oregon children and families thrive, if supported**
  - Next phase of work: engaging the "laggards"
  - Encourage community-based, multi-stakeholder approaches
  - Support multi-payor initiatives, payment reform aligns with goals and outcomes

- **What's measured is what's focused on**
  - Current incentive measures have worked in creating a focus on medical home and some of the related process
  - Future measures could focus on key attributes identified through this project (care coordination) and outcome (kindergarten readiness)

Policy Impacts to Date

- Informed federal Medicaid/CHIP and state agencies
- Informed Oregon's CCO Accountability Framework and Incentive Measures
- ECHO *Partnership* identified opportunities to enhance maternal and child health focus in CCOs
- ECHO *Partnership* informed OHA's PCPCH
- ECHO *Learning Collaborative* model informed Patient-Centered Primary Care Institute (PCPCI) models
  - Innovations spread through PCPCI Learning Collaboratives and webinars

What Does This Mean for Spread and Triple Aim?

- ECHO LC model demonstrated "*Triple Win*"
  - Increased provider efficacy, patient and family engagement, created community-based care coordination networks
- Triple Aim is achieved by focusing on promotion and prevention
  - Healthier children = healthier adults
- Ensure "meaningful" patient and family engagement and partnership; cornerstone and explicit component of health system transformation 2.0
- Consider scaling and spreading of ECHO Learning Collaborative model(s) focused on care for children
  - Intentional planning and multi-stakeholder engagement
- Continuous measurement refinement and enhancement, specific to child health
- Sustainability for practices may require broad multi-payor support specific to pediatric functions of a medical home

Oregon Health Policy Environment

- Affordable Care Act
  - Purchaser, payer, and provider reform models
  - Medicaid expansion, Marketplace, and QHPs
- Health System Transformation
  - 16 CCOs
  - Quality measures and incentives
  - Transformation Center
  - CHAs and CHIPS
  - PCPCH Program
  - Patient-Centered Primary Care Institute
- Early Learning Hubs and CCOs
- Spread of coordinated care model
- Behavioral health integration
- Task Force on the Future of Public Health
- Workforce initiatives
- Sustainable rate of growth
- Health IT/HIE-optimized health care

BREAK

Group Discussion

- What did you hear this morning that resonated?
- What levers can we use to build from these lessons learned from ECHO?
- What are the mechanisms for dissemination and spread?
- Is there information missing as we consider next steps?