

Working with Community Members: How to Engage with Awareness of the Differences between Community and Health Care Settings

Oregon Pediatric
Improvement Partnership

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Goals for Presentation & Discussion

- Quick overview of the Oregon Pediatric Improvement Partnership (OPIP) and the **population-based approach** we use to improve care for children
- Key differences between a **clinic-based** vs. a **population-based** approach to improving care that engages community-based providers.
- **Applied examples** of projects engaging community-based providers in clinic-level improvement efforts.
- Based on these examples, **tips and strategies for you in engaging with partners in the community** on your projects to improve care for patients
- Encouragement for you to consider the **policy-level implications** of your front-line improvement work and sharing them (you can do it!!!)

OPIP Mission

- OPIP supports a meaningful, long-term collaboration of stakeholders invested in child health care quality, with the common purpose of improving the health of the children and youth of Oregon.
- OPIP staff and projects are focusing on building health and improving outcomes for children and youth by:
 - 1) Collaborating in **quality measurement and improvement** activities across the state;
 - 2) Supporting **evidence-guided quality activities** in clinical practices;
 - 3) Incorporating the **patient and family voice** into quality efforts; and
 - 4) Informing **policies that support optimal health** and development
- Importance of population based approach – starting with child/family
 - Work with the multiple kinds of providers who serve children
- Primarily contract and grant funded
- Based out of OHSU, Pediatrics Department

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OPIP Steering & Partners Committees:

OPIP Steering Committee

- Children's Health Alliance Provider: Albert Chaffin, MD
- Front-Line Health Care Providers: Sandra Rood, MD (Oregon Medical Group, Eugene); Douglas Lincoln, MD, MPH, FAAP (Metropolitan Pediatrics)
- Oregon Center for Children & Youth with Special Health Needs: Brian Rogers, MD
- Oregon Health & Science University- School of Medicine: George Mejicano, MD, MS
- Oregon Health Authority – Center for Prevention & Health Promotion, Title V: Cate Wilcox, MPH
- Oregon Health Authority – Office of Health Policy and Analytics: Charles Gallia, PhD; Sarah Bartelmann, MPH; Lisa Bui; Oliver Droppers, MS, MPH, PhD
- Oregon Pediatric Society: Dana Nason, MD, FAAP; Greg Blaschke, MD, MPH, FAAP; Julie Scholz
- OPIP Parent Partner: Alicia DeLashmutt

OPIP Partners Committee

Partners are those members listed above, plus those listed below:

- Children's Health Alliance/ Children's Health Foundation: Deborah Rumsey
- Dana Hargunani, MD, FAAP (former OHA Child Health Director)
- Front-Line Health Care Providers: Ann Tseng, MD (Family Medicine, OHSU)
- Kaiser Permanente: Joyce Liu, MD
- Oregon Academy of Family Physicians: Kerry Gonzales
- Oregon Family-to-Family Health Information Center: Tamara Bakewell
- Oregon Health & Science University, Department of Pediatrics: Windy Stevenson, MD; Dana Braner, MD, FAAP, FCCM
- Oregon Health Authority – Patient-Centered Primary Care Home Program: Evan Saulino, MD, PhD
- Oregon Pediatric Society: Ken Carlson, MD, FAAP
- Our Community Health Information Network: Erika Cottrell, PhD, MPP; Brigit Hatch, MD, MPH
- Providence Health & Services: Resa Bradeen, MD

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OPIP's Goal in Working with Practices to Improve Care: GET A STRIKE...or Knock out as many Pins as Possible



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Lessons from the field
in using a **population-based** approach and the
invaluable opportunity to partner with
community based partners

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Clinic Based Approach vs Population-Based Approach

Clinic-Based Approach

- Specific to care provided in that clinic
- Specific to patients that come to the clinic
- Specific to impact during the time that the patient/family is at the clinic

Population- Based Approach

- Focus on the population of patients and the communities they reside in
- Puts the patient/family in the center of the work and recognizes that most of their time is NOT within the clinic setting
- Identifies specific functions and capacities that “live” within each setting and the value of each setting (clinic being one)
- Identifies the “nodes” between each of those stakeholders and how they would connect to each other (again, the clinic being one)

Applied Examples of Clinic-level QI Work Involving Partnerships with Community-Based Providers

Example #1: Follow-up to **Developmental Screening**

- Referring and coordinating care with community based providers

Example #2: Care Coordination in a Medical Home: **Referrals to Community-Based Providers**

- Identifying **community resources**
- **Closing the loop** with community-based referrals

Example #1:

Practice-Based QI Work on Developmental Screening

- Worked with a number of practices on improving developmental screening for young children in their clinic
- That said, the point of developmental screening isn't to just screen children
- Point of developmental screening is to make sure that children identified at-risk for delays receive follow-up services
 - Many of those follow-up services live outside traditional health care settings

Engaging Community-Based Providers in the Practice-Based QI Work on Developmental Screening

Key Steps:

1. **Community Provider Asset Mapping:** Looked outside the clinic walls and considered the community-based providers who serve young children and the risks identified
 - a) Early Intervention
 - b) CaCoon/Babies First Home Visiting
 - c) Other Home Visiting Programs (Early Head Start, Head Start)
 - d) Mental Health
 - e) Early Learning Hubs
 - f) Oregon Parenting Education Collaborative
2. **Met** with each of those community-based providers to understand what “makes them wake up worry” AND what their services are for children
 - Note: I did not say, met with each of the providers to ask how they can help you serve children better
 - Each one is serving children
3. **Identified specific methods** and ways children can be:
 - Referred
 - Communication loops can be established
4. **Piloted the methods** before going to scale to work out the kinks

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Example of HOW One of the Community-Based Providers Was Engaged in Improving Developmental Screening:

*Example Community-Based Provider: **Early Intervention***

- First reviewed what Early Intervention is and what services they provide (AKA: Did some **background research** and reading)
- Met with EI to have a conversation about the **shared goal** of improving early identification of young children with delays to receive services
 - Within EI, asked them about **their goals and frustrations** and how could the clinic-based project address their needs (not just the clinic's needs)
- Shared barriers the practice was experiencing and asked for their insight
 - Note: I did not say “I can’t do X, you need to do Y”
- Identified areas of **shared interest** that could be feasibly addressed during the project

Example of How EI Engaged in Clinic-Based QI Project to Improve Follow-Up to Developmental Screening

Tools Developed to Support Collaboration and Coordination

- Universal Referral form that addresses requirements within health care and within education
 - Included in the referral form are agreements about what information health care with would share with EI and what information EI would then share back with health care
- Communication templates
 - For when child is unable to be contacted by EI
 - For when a child is ineligible
 - For when a child is eligible
- Education sheet for families, provided by PCP, about the community-based referrals they are being referred to

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Applied Examples of Clinic-level QI Work that Involved Partnership with Stakeholders in the Community

Example #1: Follow-up to **Developmental Screening**

- Referring and coordinating care with community based providers

Example #2: Care Coordination in a **Medical Home**

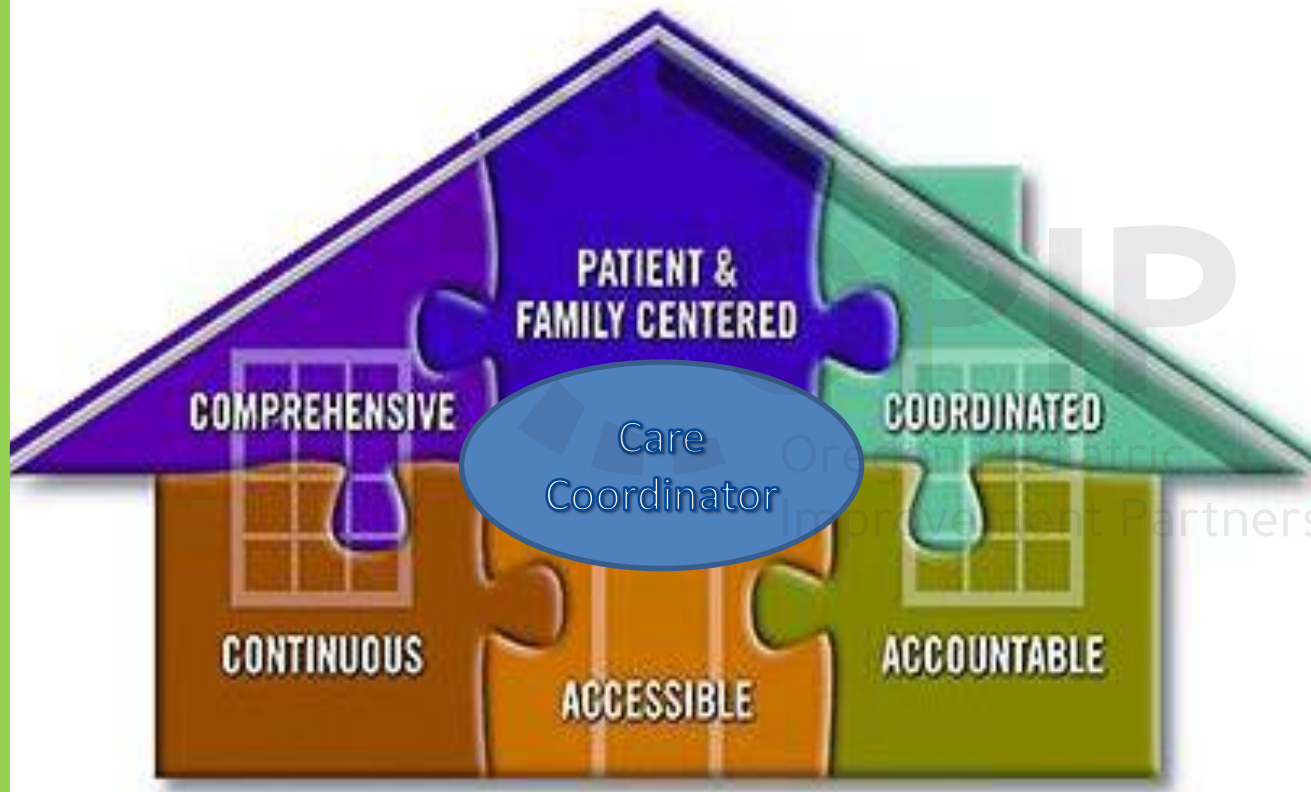
- Identifying **community resources** to support your patient
- **Closing the loop** with community-based referrals

Practice-Based QI Work Focused on Patient Centered Primary Care Home Standards (PCPCH) Related Care Coordination

- **Specific functions within the primary care medical home**
 - Shared Care Plans
 - Referral Tracking and Management – Includes referral to community-based resources
 - Community resources mapping

Care Coordinators:

The “Node” within Practices and Teams



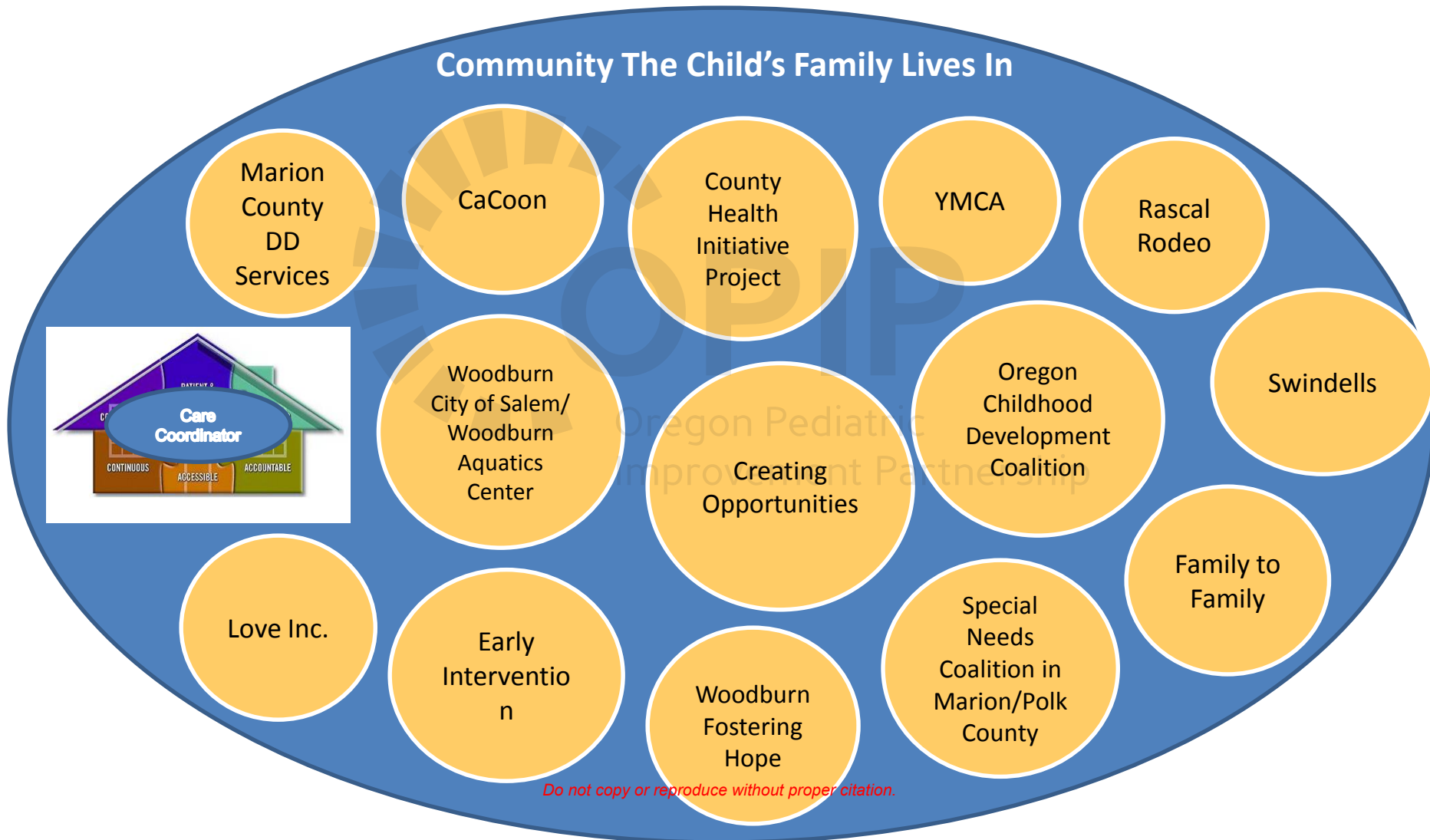
Example:

Resources that **Care Coordinators** from a 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 that Are Connectors to Community-Based Resources

Example from one clinic we have worked with:



Engaging Community-Based Providers in the Practice-Based QI Referral Coordination - Closing the Loop

Key Steps:

1. **Identify** the primary referrals that you want to close the loop with
 - Most prevalent referral **OR**
 - Referral you are most concerned about the loop closing **OR**
 - Referral for which you have observed patients are least likely to access
2. **Meet** with the referral entity to understand what “makes them wake up worry” AND what their services are for children
 - Note- Again: I did not say, met with each of the providers to ask how they can help you serve children better
3. Identify specific **methods and ways** children can be:
 - Referred
 - Communication loops can be established
4. Pilot the methods before going to scale to work out the kinks

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Practice-Based QI Work on Community Resources Mapping

Approaches to Identifying Community Resources

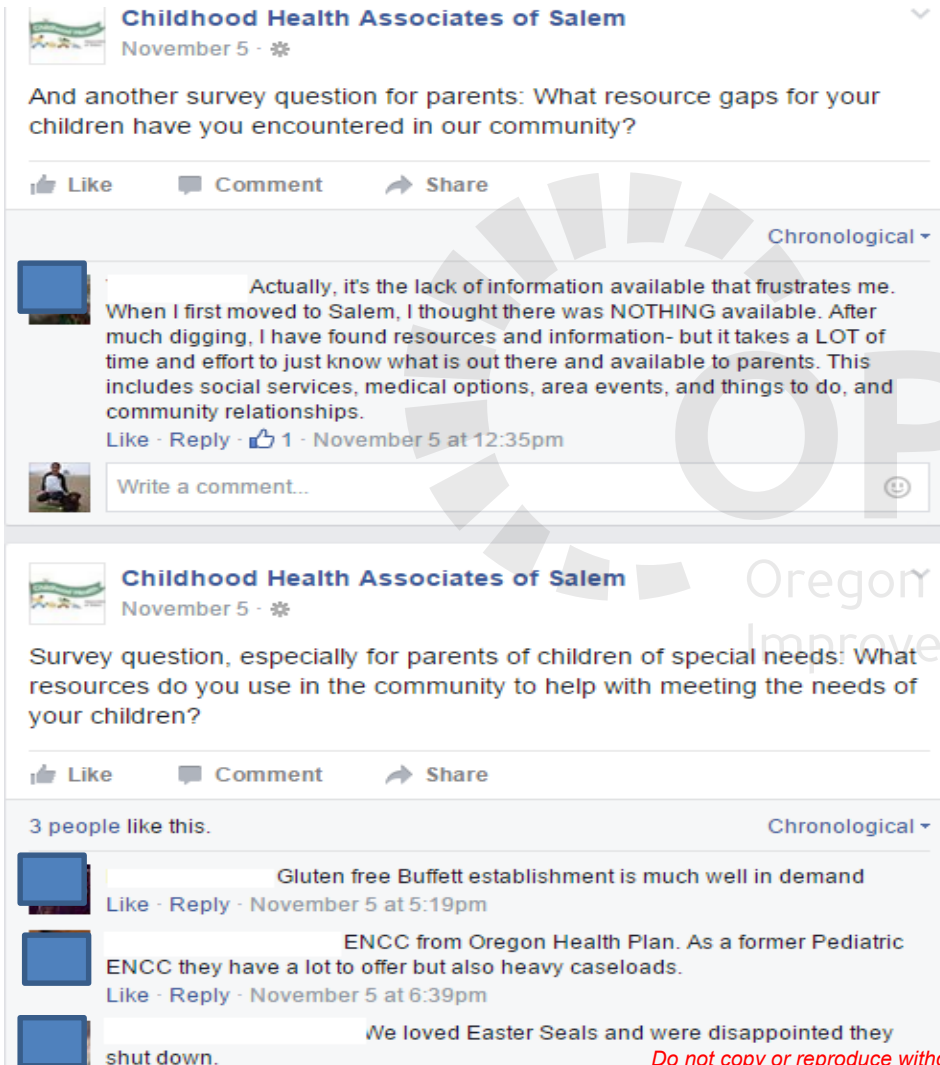
- **Determine if a resource inventory or directory already exists in the community.**
 - Check with your local health department, the hospital's education department, senior citizen centers, community action agencies, parks and recreation departments.
 - Consider if a modification of an existing directory will work for you.
- **Look online.** Search community and service specific headings.
 - This approach is most helpful in *supplementing* resource list already created.
- **CRITICAL TO ANY APPROACH: ASK YOUR PATIENTS!** – They are local 'experts' that utilize the resources. They may know of resources that you don't, and may have insight to share about their experiences and knowledge of the resource.

Examples from Practices: Identify the Resources in Your Community

Three Practices we have worked with have surveyed their families to understand resources families use.

Approaches each Practice took:

1. Hosted a local organization who supports families to present at a Family Advisory Meeting and then asked families to share about other community organizations that they have utilized
2. Surveyed families that came in for flu clinic
3. Posted questions on their clinics Facebook page



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Contacting Community-Based Resources

- **Assign the task of reaching out**
 - It may help to divide the list among staff members and ask them to contact each resource
- **Collect common information from all resources**
 - It would be best to conduct the follow up interviews in person if you are able.
 - The ability to actually see the resource and not rely on a web site or professional photo to determine its cleanliness, professionalism, and value is helpful.

"Good Morning (afternoon), I'm (name) calling from the (name of clinic), here in (name of community). We are trying to improve our understanding of resources in our community, so we can better coordinate and communicate with them in partnership with our patients. We are building a resource directory of all the resources here in (name of the community) that help with (insert topic). We'd like to learn more about (name of resource) and perhaps build a relationship with your organization. Who should I speak to?"

Now to focus on you and the work you
will be doing.....

Tips for You in Engaging Community- Based Providers in Your Projects

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Tips for You: Part 1 - General Communication Strategies

- Recognize the value and good intent of others
 - Assume good intent
 - Assume that each person wants to the best, but they are often stuck within systems or funding that may not allow them to do all that they want
 - Most people are frustrated by fragmentation of systems too
- Acknowledge that health care is one small part of health and where patients live
- Remember that not everyone knows about health care and what health care does
 - Minimize use of acronyms
 - Assume people don't have context
- Put the patient in the center
 - Put the person and the area of focus at the start and center of the conversation
- Hear about what the other person does and “wakes up and worries about”
- Identify areas of shared interests and goals with your clinic and project goals and their program
- Realize that many community-providers want engagement with and partnership with health care providers
 - Often have lacked opportunity, time, or knowledge to be able to do this
- That said, recognize that some community-based providers may also have had bad experiences in working with health care providers
 - Many community-based providers we have worked have noted negative experiences (and likely vice versa 😊)

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Tips for You: Part 2-

Preparing for Meetings with Community-Based Providers

- Do your research on the program itself
- Depending on the topic, leverage statewide resources that may have focused on the areas you are interested in & build off that work
 - Patient Centered Primary Care Institute Website: Webinars and blogs
 - Oregon Health Authority- Transformation Center - <http://www.oregon.gov/oha/Transformation-Center/pages/index.aspx>
 - Oregon Health Authority – Public Health:
 - <https://public.health.oregon.gov/Pages/Home.aspx>
 - https://public.health.oregon.gov/HealthyPeopleFamilies/Babies/HealthScreening/ABCD/Pages/early_childhood_systems.aspx
 - Your CCOs
 - www.oregon-pip-org
 - Professional Organizations (Oregon Pediatric Society, Oregon Academy of Family Physicians)

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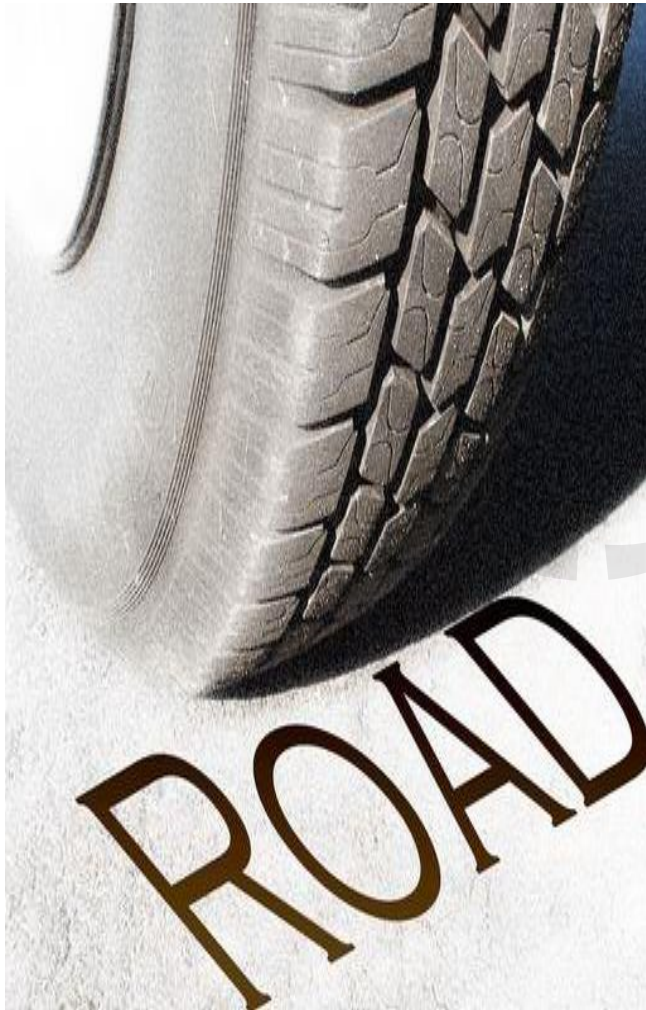
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*A gentle nudge to think about how you can share
and disseminate your project level findings to
inform policy (or system)-level improvement*

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Invaluable Perspective You will Have from the **Front-Line**:

Why it is important to share with policymakers



- Most of your projects focus on topics that systems and policymakers are focused (PCPCH, Behavioral Health)
- You will be gathering rich information on:
 - Realities of implementation
 - Positive impacts of policies
 - Unintended negative consequences
 - Complexity of the nuances within each system, they are often within one system
- Informing policymakers creates a common pool of knowledge: shared goal of improved care for patients

Who is a Policymaker & How Does that Relate to Your Clinic-Level QI Work?

- Policies are systems
- There are policies with a capital “P” and policies with a small “p”
- So policy-makers are those people who can impact system-level factors. This means they can include people that control systems related to:
 - ✓ Claims/bills
 - ✓ EMR templates and forms
 - ✓ Provider manuals
 - ✓ Referral networks
- For your projects, remember system-level leader are “policymakers”. Focus on policies with the small “p”
 - *Examples: Health system leaders, county public health*

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Successful Strategies OPIP has Used to Inform Policies

Engage:

- Strategic meetings with policymakers to summarize projects

Educate:

- Develop strategic and SHORT summaries inform specific policies
- Develop strategic issue briefs to inform policymakers

Inform:

- Serve on policy forming committees
 - *Examples: CCO or Health System Clinical Advisory Panels, Early Learning Hub Partners*

Partner:

- Propose solutions
- Propose partnership to identify solutions
- Partner to help translate policies to the front-line

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What We Have Learned Makes Successful Feedback

- Know what **levers the policymaker can access**, avoid feedback on something they can't address
- Provide **tangible and specific information** about the practice-level experience that directly relates to policies they can impact
- If possible, **provide solutions** OR offer to be part of the solution generation process
- **Round back to your practice** about the work with the policymakers
 - Gives them credit for their hard work
 - Helps provide perspective to both parties

Applied Example of Using Practice-Level Learnings To Inform Improvements to Policies: The “Treasure Valley” Experience

- Through PCPCI, had the honor of working with Treasure Valley Pediatrics in Ontario, OR
- Treasure Valley part of the original learning collaborative upon which the definition of medical home was developed
 - Already had care coordinators and many meaningful systems
 - Uncertified within PCPCH
- Co-located mental and behavioral health staff
 - However experienced a number of policy barriers



Reimbursement Challenges for a PCPCH with Integrated Mental and Behavioral Health: Case Study from Treasure Valley Pediatric Clinic (Ontario, Oregon)

PURPOSE

The purpose of this document is to highlight reimbursement challenges faced by Treasure Valley Pediatrics (Ontario, OR) for services provided to Oregon Medicaid patients in a practice with integrated mental and behavioral health services.

BACKGROUND

Treasure Valley is a certified Patient Centered Primary Care Home (PCPCH) medical home (Tier 3). Over a decade ago, Treasure Valley was one of the flagship sites in the development and pilot of the concept of medical home defined by the American Academy of Pediatrics and Center for Medical Home. As a result of their internally driven efforts to aim to be a medical home for children and youth, Treasure Valley identified the importance of integrated mental and behavioral health services. They have seen the benefit to the health and well-being of their patients in offering these services within the medical home, and have made this an integral part of the care team.

Within the Oregon PCPCH standards (Standard 3C – a Must Pass Standard, See Appendix A) there is an explicit emphasis on practice-level integration of services that has now created external drivers that seek to promote this model. Additionally, there is an emphasis on behavioral integration in requirements for the Coordinated Care Organization (CCO) and related Incentive Measures (See Appendix A).

However, despite these policies and Treasure Valley achieving the metrics outline for practices, they are experiencing that the payment and reimbursement to support these services is denied and thereby making it unfeasible for the practice to provide the co-located services.

On the following pages we have described how the services are co-located at Treasure Valley Pediatrics and the policy and payment level barriers.

Behavioral Health at Treasure Valley Pediatrics

At present, Treasure Valley employs five behavioral health specialists, including 2 Licensed Clinical Professional Counselors (LCPC), two Licensed Clinical Social Workers (LCSW), and one Psychiatric Mental Health Nurse Practitioner (PMHNP). These specialists are co-located; they take appointments in the practice in specially designed rooms, and are available for 'warm hand-offs', ad hoc, and ongoing collaboration with medical providers. That said, given the issues outline in this memo, this co-located model developed based on their patient needs may not be financially sustainable.

CHALLENGES AND IMPACT EXPERIENCED BY A TIER III PCPCH

Reimbursement for Behavioral Health Professional Services

The behavioral health services provided at Treasure Valley are not reimbursable for Oregon Medicaid patients. Mental and behavioral health services at Treasure Valley are available to those who are privately insured, or who have Idaho Medicaid coverage. Patients who receive coverage from Oregon Medicaid are assigned to Greater Oregon Behavioral Health Inc. (GOBHI) to manage their mental health. GOBHI contracts with Lifeways of Oregon to provide all mental and behavioral health services to Medicaid patients residing in this region. As such, it is requested that all patients are referred to Lifeways of Oregon directly for mental/behavioral health services (regardless of diagnosis or circumstance), and thus any claims submitted for mental/behavioral health care provided by mental and behavioral health specialists in the primary care setting are denied. The Treasure Valley mental health

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Applied Example of Using Practice-Level Learnings To Inform Improvements to Policies: The “Treasure Valley” Experience

- Shared brief with the OPIP Partners
 - At this meeting key stakeholders identified to target the findings
- Met and shared the brief with:
 - Child Health Director
 - Staff within the Oregon Health Authority (OHA)
 - Innovator Agent for the local Coordinated Care Organization, within the OHA Transformation Center
 - Staff from the Coordinated Care Organization (CCO)
- A number of policy improvements implemented addressing specific barriers



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Final Thoughts



If you do nothing else...

1. **Take a population-based approach to your clinic-level work**
2. **Identify key stakeholders in your community who have a shared interest in the GOAL and OUTCOME of the systems and processes you are implementing in your clinic-level project**
3. **Do your homework – learn about these resources**
4. **Meet with priority stakeholders and use the tips provided to have a collaborative and meaningful conversation**
5. **Put the patient in the center ...and go from there.**

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Sharing Your Experiences & Brainstorming for The Future

- What resonated in what I shared with you?
- Who has had a great experience with engaging community-based providers in their clinic-level work?
 - What additional tips would you provide?
 - What were the keys to success?
- As you think about your projects, what opportunities exists?
- Questions?