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  Appendix B: Overview of OPIP Practice Facilitation
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OPIP Vision and Mission

**OPIP Vision:**
To create 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 Mission:**
The Oregon Pediatric Improvement Partnership is a public-private partnership dedicated to building health and improving outcomes for children and youth by:
- collaborating in quality measurement and improvement activities across the state,
- supporting evidence-guided quality activities in clinical practices,
- incorporating the patient and family voice into quality efforts, and
- informing policies that support optimal health and development for all children and youth

Purpose of the Annual Report

The purpose of this annual report is to summarize the priority activities and highlight key learnings gathered over the last year. OPIP was formally established in July 2010, with financial support from the Department of Pediatrics at OHSU and project-level contracts. Therefore, the annual report summarizes work from July 1 - June 30 of the associated fiscal year.

This annual report is distributed to those who collaborate and partner with OPIP, or who are invested in improving the health of children and youth in Oregon. Given this specific audience and their general awareness of health and improvement terms, and in the interest of brevity, there are a number of acronyms used throughout this report. *Appendix A* provides a list of acronyms and their definitions.
Overview of Current OPIP Projects

A cornerstone of OPIP’s project-level work is working with practices and health systems to improve care on the front-line, use meaningful data to gauge these efforts, and identify policy level implications and improvements. A key component of our staffing structure and work is in the use of practice/system-level facilitators to guide improvement efforts at the ground-level, and ensure that evidence-based strategies are implemented and sustained. Appendix B provides an overview of OPIP’s Practice Facilitation. Throughout this work, OPIP has the opportunity to work with 26 front-line practices; 16 Pediatric primary care sites, 9 Family Medicine, and the Southcentral Foundation health system. Additionally, through the Assuring Better Child Development work, we worked with eight Managed Care Organizations that cover one in three children in the state.

In the last year, OPIP had four main projects:

1) Assuring Better Child Health & Development-III “ABCD III” (November ’10 – October ’12)
   - OPIP served as the External Quality Review Organization-like (EQRO) and facilitated a learning collaborative of eight Medicaid Managed Care Organizations (MCOs). The learning collaborative was part of the MCOs’ Performance Improvement Project (PIP) focused on screening, referral, and care coordination for children at risk for developmental, behavioral, and social delays. OPIP facilitated the learning curriculum, which was developed and informed by community-based cafés that engaged a variety of stakeholders (including families), developed a medical chart review abstraction tool, and analyzed the evaluation data collected for the project.

2) Tri-State Children’s Health Improvement Consortium “T-CHIC” (March ’10 – March ’15)
   - OPIP is part of the leadership team for this tri-state alliance between the Medicaid/CHIP programs of Alaska, Oregon, and West Virginia. The shared goal of T-CHIC is to markedly improve children’s health care quality. OPIP’s role is to help lead the T-CHIC effort, design the learning curriculum and the “learning collaborative of collaboratives” across the three states, consult on data collection and reporting of the CHIPRA core measures, and lead the medical home quality improvement measurement and evaluation.
   - As a component of the T-CHIC work, OPIP was contracted to work specifically with the Alaska T-CHIC team to provide consulting and technical assistance to enhance and improve their medical home learning collaborative efforts.

3) Enhancing Child Health in Oregon – Medical Home Learning Collaborative “ECHO” (June ’11 – June ’14)
   - ECHO is a Learning Collaborative focused on practice-level medical home transformation for children and youth. ECHO is a component of the T-CHIC effort focused on provider-based models of improvement in Oregon,
   - OPIP leads the development of the Learning Curriculum and is collaborating with the Oregon Rural Practice-Based Research Network. Face-to-face learning sessions are held every six months, in addition to monthly practice facilitation and monthly webinars that support the practices in their transformation efforts. The effort engages eight Pediatric and Family Medicine practices in medical home transformation. OPIP conducts monthly facilitation with five of the sites.

4) Subcontract from the Patient-Centered Primary Care Institute “PCPCI” (October ’12 – October ’13)
   - Oregon Health Care Quality Corporation was awarded the contract to facilitate the Patient-Centered Primary Care Institute. The Institute is a public-private partnership between the Oregon Health Authority, Oregon Health Care Quality Corporation, and the Northwest Health Foundation.
   - OPIP applied to a request for proposal for partners in The Institute and was awarded a year-long subcontract. A key component of this work is to lead a Pediatric Learning Collaborative of five pediatric clinics across the state focused on patient-centered medical home and practice-level transformation. Additionally, OPIP participates in the PCPCI “Expert Learning Network” and “Train the Trainer” activities. See www.pcpci.org for more information.

Figure 1 on the next page provides a high-level overview of the key partners, measures, and improvement areas of focus within each of these projects.
## Figure 1: July ’12-July ’13

**Overview of OPIP Measurement and Improvement Projects: Collaborators, Measures, and QI Focus**

### Assuring Better Child Health & Development-III
(Subcontract from DMAP, Served as EQRO-Like Organization Facilitating Performance Improvement Project; Project Formally Ended 10/12)

<table>
<thead>
<tr>
<th>Collaborative Partners:</th>
<th>Measures – Data Source:</th>
<th>Quality Improvement Focus:</th>
</tr>
</thead>
<tbody>
<tr>
<td>OHA/DMAP</td>
<td>Claims/Enrollment Data</td>
<td>Learning collaborative of 8 MCOs</td>
</tr>
<tr>
<td>Center for Prevention &amp; Health Promotion</td>
<td>Medical Chart Reviews</td>
<td>QI goals specific to children at risk for or with social, emotional or developmental delays</td>
</tr>
<tr>
<td>Early Intervention (State, Local Contractor)</td>
<td>Population-based surveys</td>
<td>Collaborative has four goals specific to screening/surveillance, referral, tracking of referrals and ensuring children get to services, and care coordination</td>
</tr>
<tr>
<td>Eight Managed Care Organizations (MCO)</td>
<td>Qualitative data (interviews, cafes)</td>
<td></td>
</tr>
<tr>
<td>ABCD III Advisory group (broad stakeholders)</td>
<td>MCO Baseline Assessment</td>
<td></td>
</tr>
<tr>
<td>Parents who participated in engagement</td>
<td>Early intervention data</td>
<td></td>
</tr>
<tr>
<td>Providers who participated in engagement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Title IV/ OCCCYSN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>START (presented at meetings, did trainings)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Tri-State Children’s Health Improvement Consortium (T-CHIC)
(Five Year Subcontract from OHPR/ One Year Contract with AK TCHIC Team)

<table>
<thead>
<tr>
<th>T-CHIC Collaborative Partners:</th>
<th>Measures – Data Source:</th>
<th>T-CHIC Quality Improvement Focus:</th>
</tr>
</thead>
<tbody>
<tr>
<td>OHA: DMAP, OHPR</td>
<td>CHIPRA Core Measures</td>
<td>Focus on medical home transformation across all three states</td>
</tr>
<tr>
<td>TCHIC Partners in WV and AK (Medicaid, CHIP and Private Partners working on QI)</td>
<td>Claims/Enrollment Data</td>
<td>Learning curriculum also focused on meaningful, useful quality measurement and how it can be improved and used to guide/track improvement efforts</td>
</tr>
<tr>
<td>CAHM (Up to February ’13)</td>
<td>Medical Chart Reviews</td>
<td>OIP assisting on the across T-CHIC Learning Curriculum</td>
</tr>
<tr>
<td>21 primary care practices</td>
<td>Other data sources</td>
<td>AK Contract Focus</td>
</tr>
<tr>
<td>Title IV/ OCCCYSN</td>
<td>CAHPS® CG PMCH</td>
<td>Methods for facilitating a Learning Collaborative; dev. learning curriculum</td>
</tr>
<tr>
<td></td>
<td>Population-based surveys</td>
<td>- Meaningful use of quality measures</td>
</tr>
<tr>
<td></td>
<td>T-CHIC Medical Home Office Report Tool (MHORT)</td>
<td>- Developmental screening</td>
</tr>
<tr>
<td></td>
<td>Surveys – Providers and office staff</td>
<td>- Shared care plans</td>
</tr>
<tr>
<td></td>
<td>CAHPS® CG PMCH</td>
<td>- Patient engagement in QI</td>
</tr>
<tr>
<td></td>
<td>Qualitative data</td>
<td></td>
</tr>
</tbody>
</table>

### Contract with Alaska Team- Partners:
- AK Medicaid/CHIP
- AK practice sites (2 family medicine practices, South Central Foundation)

### Enhancing Child Health in Oregon (ECHO) - Medical Home Learning Collaborative
(Three Year Contract from OHPR)

<table>
<thead>
<tr>
<th>Collaborative Partners:</th>
<th>Measures – Data Source:</th>
<th>Quality Improvement Focus:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORPRN</td>
<td>TCHIC Medical Home Office Report Tool (MHORT)</td>
<td>Focus on medical home transformation</td>
</tr>
<tr>
<td>OHA: DMAP, OHPR</td>
<td>Surveys – Providers and office staff</td>
<td>OIP leading the development of the Learning Curriculum and Learning Collaborative (with collaboration from ORPRN)</td>
</tr>
<tr>
<td>Title IV/ OCCCYSN</td>
<td>CAHPS® CG PMCH</td>
<td></td>
</tr>
<tr>
<td>Eight primary care practices across the state</td>
<td>Qualitative data</td>
<td></td>
</tr>
</tbody>
</table>

### Patient-Centered Primary Care Institute
(Contract from Quality Corporation)

<table>
<thead>
<tr>
<th>Part 1: Lead Pediatric Practice Learning Collaborative</th>
<th>Measures – Data Source Related to Part 1:</th>
<th>Quality Improvement Focus:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaborative</td>
<td>PCPCI Baseline Assessment</td>
<td>Focus on medical home transformation</td>
</tr>
<tr>
<td>Collaborative Partners:</td>
<td>Surveys – Providers and office staff</td>
<td>Specific target areas of training and facilitation focused on care coordination, patient engagement in QI, family and professional partnership, and use of patient experience of care survey data to guide QI</td>
</tr>
<tr>
<td>Five pediatric primary care practices across the state</td>
<td>Qualitative data</td>
<td></td>
</tr>
<tr>
<td>PCPCI – PCPSI – OPCA</td>
<td>PCPCI Attestation</td>
<td></td>
</tr>
<tr>
<td>Part 2: Expert Learning Network</td>
<td>CAHPS® CG and CAHPS® CG PCMH in selected sites</td>
<td></td>
</tr>
<tr>
<td>Aucenatra – CareOregon – CareSync</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORPRN – OPCA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part 3: Train the Trainer Activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple organizations across the state</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Overview of OPIP Facilitation and Improvement Coaching: Topics Assessed

Through OPIP’s work with practices and health systems, we facilitate Learning Collaboratives. As a part of these Learning Collaboratives, we develop materials that distill, summarize, and provide actionable information that can be used to transform care. This information is disseminated through in-person Learning Sessions or webinars. Additionally, OPIP has been asked to develop webinars for state and national audiences. Figure 2 provides a summary of the topics OPIP has developed improvement coaching and education materials during this annual report period.

Figure 2: July ’12-July ’13 Summary of Topics for which OPIP Developed/Facilitated Improvement Coaching Presentations

<table>
<thead>
<tr>
<th>Comprehensive Medical Home</th>
<th>Quality Measurement and Meaningful Use of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric Medical Home Innovation: Spotlight from Practices in Oregon</td>
<td>Measuring your efforts: Considering meaningful metrics for your QI effort</td>
</tr>
<tr>
<td>Patient Centered Primary Care Home (PCPCH): Overview of key elements for a pediatric medical home: development and evolution of the standards</td>
<td>How to Use Data to Improve Care Delivery - AAP Webinar Series* (Co-presented with Christina Bethell)</td>
</tr>
<tr>
<td>Medical Home Innovation: Spotlight of innovative and exciting improvement work in the practices and policy level implications* (Led call and co-presented with T-CHIC partners)</td>
<td>Visual Data Display: How do IP’s Most Effectively Share Data to Inform and Engage QI Teams - NIPN Operational Meeting* (Co-presented with Sara Barry, VHPB)</td>
</tr>
<tr>
<td>Family risk assessment - Screening for Post Partum Depression* (Wendy Davis, Postpartum support International)</td>
<td>Effective Use of Data Across the National Improvement Partnership Network (NIPN): Examples of Different Strategies and Methods for Data Dissemination and Presentation - NIPN All Sites Call (Led call co-presented with DC, ME, and UT)</td>
</tr>
<tr>
<td>Medical home: Essential components for children exposed to violence* (Terri Fairchild, Defending Childhood Initiative)</td>
<td>Developmental Screening in the First Three Years of Life: Innovative State Approaches to Collecting, Reporting, and Using the Measure to Improve Care® - CMS sponsored webinar series (Led call co-presented with five states)</td>
</tr>
<tr>
<td>Medical home: Essential components for children exposed to violence - AAP Webinar Series version</td>
<td>Measurement of Developmental Screening, Referral and Follow-Up: Key Learnings and Future Opportunities</td>
</tr>
<tr>
<td>Adolescent SBIRT* (Full presentation by Greg Blanchard, OHSU/OPHS)</td>
<td>Patient Experience of Care Surveys: How They Are Part of Your Medical Home Transformation Efforts</td>
</tr>
<tr>
<td>Follow-up for children prescribed medications for ADHD</td>
<td>Overview of the Consumer Assessment of the Healthcare Providers and Systems (CAHPS®) Clinicians &amp; Group: Patient-Centered Medical Home (PCMH) and reports provided.</td>
</tr>
<tr>
<td>Screening for adolescent depression</td>
<td>CAHPS® CG PCMH Findings: What do they mean and how can your practice use the findings, what have you learned? (Led call and co-presented with 3 T-CHIC practices)</td>
</tr>
<tr>
<td>Practice Tools and Resources Related to Behavioral Health Screening</td>
<td>Medical Home Evaluation Data: Where are we now, how we have improved, and what unique information does the CAHPS® CG PCMH findings give us as it relates to family-professional partnerships</td>
</tr>
<tr>
<td>Practice Readiness Assessment Around Behavioral Health Integration</td>
<td>Using the Office Reported Medical Home Office Report Tool (MHORT) to Guide Improvement Efforts</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Coordination</th>
<th>Incorporating the Patient and Family Voice into Quality Effort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care coordination for children and youth – Overview of functions and highlight of T-CHIC data about innovations and areas for improvement</td>
<td>How to Ensure a Patient-Centered focus in your Medical Home transformation efforts (Shelley Barnes, OCCC/HCN)</td>
</tr>
<tr>
<td>The What, Why, Who and How of Care Coordination: A Symphony in B flat (Full presentation by Bob Nicoli, OCCC/SHIN and Alicia DeLashmutt, OPIP Patient Partner)</td>
<td>Patient Engagement - A Family Perspective* (Full presentation by Shelley Barnes and Tam Montesano)</td>
</tr>
<tr>
<td>Care Coordination in T-CHIC: Core aspects identified, current strengths and strategies, related tools and resources, health policies that can support these efforts</td>
<td>Parents as Partners in Quality Improvement* (Shelley Barnes, OCCC/HCN)</td>
</tr>
<tr>
<td>Care Coordination: Spotlight on Innovative strategies, tools and methods from T-CHIC practices* (Led call and co-presented with 3 T-CHIC practices)</td>
<td>Leveraging Parents in Your QI Efforts</td>
</tr>
<tr>
<td>Shared Care Plans (Three different webinar bars)</td>
<td>Parents as Partners in Quality Improvement: At an organization, project and practice level - NIPN_All Sites Call</td>
</tr>
<tr>
<td>Referral Tracking and Management-Overview of key issues to consider</td>
<td>Family and Professional Partnerships: A Cornerstone of Medical Home Transformation Efforts - CMS CHIPRA Grantee Call* (Shelley Barnes, OCCC/HCN)</td>
</tr>
<tr>
<td>Referral Tracking and Management: Key issues to Consider &amp; Examples of innovation</td>
<td>Building QI Improvement Infrastructure / Adaptive Reserve</td>
</tr>
<tr>
<td>Health Literacy* (Full presentation by Cliff Coleman, OHSU)</td>
<td>Developing a successful QI project: Building blocks and tools for testing small changes</td>
</tr>
</tbody>
</table>

Update and Overview of Oregon Health Reform Efforts

<table>
<thead>
<tr>
<th>Update on PCPCH Proposed Revisions</th>
<th>The Good, The Bad and the Ugly: Examples of QI projects in practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of OIP and OPIP Partners Feedback to PCPCH Standards</td>
<td>Thinking of Sustainability and Spread Now: Intentionally building your project team &amp; ensuring clinician engagement</td>
</tr>
<tr>
<td>Update on Revised PCPCH Standards</td>
<td>Innovative Project Designs – Designed for persons working with practices and presented at the National Improvement Partnership Network Meeting</td>
</tr>
<tr>
<td>PCPCH Certification vs. Enhanced Payment: Understanding the difference and potential implications for project planning</td>
<td>Teamness* (Full presentation by Ron Stock, OHSU)</td>
</tr>
<tr>
<td>Update on CCO Incentive metrics and impact on primary care providers</td>
<td>Tools and strategies to adapt the pediatric behavioral health CCO Incentive metrics</td>
</tr>
</tbody>
</table>

Oregon Pediatric Improvement Partnership: Annual Report July 2012 - July 2013 6
Highlights of the Year

Project-Level Successes

**Assuring Better Child Health & Development-III (ABCD III):**
- Concluded contract, developed and disseminated final reports to each of the eight Medicaid Managed Care Organizations focused on screening, referral, and care coordination for children at risk for developmental, behavioral and social delays.
- Developed and disseminated a final report to the Division of Medical Assistance Programs (DMAP) summarizing the findings across all eight MCOs and the implications. Based on DMAP’s request, OPIP individually met with a number of stakeholders within Oregon Health Authority and Early Learning Council to share the learnings and to ensure they were considered in the health reform and early learning system redesign efforts.
- Five of the eight MCOs which participated in ABCD III have chosen to continue work in this area through their current External Quality Review efforts. Based on their request, OPIP has met with each of these entities to provide guidance and input on their next phase of work.
- The findings from ABCD III were influential in the selection of Developmental Screening as an incentive metric for the Coordinated Care Organizations.

**Tri-State Children’s Health Improvement Consortium (T-CHIC):**
- Ms. Reuland served as the lead author of a Child Health Services and Research (CHSR) 2013 poster presentation about the positive impact T-CHIC has had on improving quality of care for children and adolescents. Figure 3 shows the average improvements in MHI-RSF® and NCQA PCMH © 2011 scores across T-CHIC.
- OPIP spoke on behalf of the T-CHIC on a national webinar sponsored by the Centers for Medicare and Medicaid services. The webinar was focused on Family and Professional Partnerships: A Cornerstone of Medical Home Transformation Efforts, and was done in collaboration with Shelley Barnes from the Oregon Center for Children and Youth with Special Health Needs.

“T-ChIC is a partnership among AK, OR, and WV Medicaid and CHIP programs. OPIP has successfully supported the goal of the tri-state consortium to improve the quality of children’s health and health care. Through the work and leadership of OPIP, the tri-state project has effectively informed State and Federal policy discussions on the challenges and lessons learned around quality improvement and practice level transformation. More importantly, OPIP has directly worked with practices in Oregon, Alaska and West Virginia—helping to benefit thousands of patients and their families in communities in each state. Through engaging in collaboration, demonstrating leadership, and a willingness to step up, OPIP is an early leader in pediatric practice transformation.”

Oliver Droppers IV, MS, MPH; T-CHIC Project Director, Oregon Health Authority, Office of Health Policy & Research
**Enhancing Child Health in Oregon (ECHO) - Medical Home Learning Collaborative:**

- OPIP continued to work with eight Pediatric and Family Medicine practices across the state engaged in medical home transformation. OPIP, in collaboration with the Oregon Rural Practice-Based Research Network (ORPRN), conducted face-to-face learning sessions every six months that were focused on care coordination, behavioral health integration, and family professional partnerships.
- Across Oregon, improvements were observed on the quality domains within the Medical Home Index-Revised Short Form (specific to children and youth with special health care needs) and NCQA PCMH® 2011 (see Figure 4).

**Patient Centered Primary Care Institute (PCPCI) Pediatric Medical Home Learning Collaborative**

- OPIP is working with five pediatric practices across the state. The five practices started the collaborative without being certified as Patient Centered Primary Care Homes (PCPCH). As of July 2013, three of five of the sites had become certified, with the remaining two expected to certify by the conclusion of the project.
- Participating practices worked on processes to enhance their quality improvement infrastructure, engage patients in quality improvement, meaningful use of patient experience of care surveys, and enhanced care coordination functions.

**Ensuring Synergy Around Efforts to Improve Care & Informing Health Reform**

- Created the OPIP Partners Committee to ensure shared learnings across stakeholders invested in improving child health in Oregon (see pages 36-37 for more information).
- Participated in a number of committees informing health reform (see pages 37-38).
- Developed and disseminated four briefs meant to inform health reform efforts, such as the Patient Centered Primary Care Home program and Coordinated Care Organization development (see pages 31-32).
- Dr. Gillespie was a Plenary Session speaker for the American Academy of Pediatrics National Conference and Exhibition, “Ensuring Quality: What can be done at Your Practice.”

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Lisa Kranz, MBA, CMPE  
Family Medical Group NE- Portland, OR

Sandra Dunbrasky, MD  
Treasure Valley Pediatric Clinic- Ontario, OR

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*Figure 4: Average Change in Quality of Care Scores for NCQA PCMH® 2011 Domains Across ECHO Practices*
Highlight of Key Activities Relative to the OPIP Mission

On the following pages is a high-level summary of the key activities, by project (where possible), that have been conducted relative to the four primary strategies of the OPIP mission. Project-specific summaries are also available on the OPIP website (www.oregon-pip.org).

Activity #1: Collaborating in Quality Measurement and Improvement

Assuring Better Child Health and Development-III (ABCD III) in Oregon:

The ABCD III project sought to make improvements in policies and systems in order to better identify, refer, and coordinate care for children at-risk for developmental, social and behavioral delays. In Oregon, the Division of Medical Assistance Programs (DMAP) leveraged the Performance Improvement Project (PIP) structure required as part of the Medicaid Managed Care Organization (MCO) contracts. OPIP was hired to serve as the External Quality Review Organization-like (EQRO) for ABCD III. As part of this role, we developed the ABCD III PIP, informed by community engagement with parents and providers, and facilitated a Learning Collaborative of eight managed care organizations. This included a learning collaborative process through monthly meetings with the plans, periodic one-to-one check-ins, and monthly summary reports on each plan’s progress. A component of the PIP was a medical chart review conducted by the eight managed care plans to assess screening and surveillance, referral tracking, and care coordination patterns documented in the chart. OPIP developed the medical chart specifications that were used by the MCOs. OPIP also supported analysis of this medical chart data. Additionally, OPIP supported efforts focused on engagement and shared learning between community-level partnerships needed for the ABCD III effort to be successful with Early Intervention, CaCoon, and other community based providers.

Highlights of Key ABCD III Activities and Learnings Related to Measurement and Improvement:

- Concluded contract, developed and disseminated final reports to each of the eight Medicaid Managed Care Organizations focused on screening, referral, and care coordination for children at risk for developmental, behavioral and social delays.
- Developed and disseminated a final report to DMAP summarizing the findings across all eight MCOs and the implications. Based on DMAP’s request, OPIP individually met with a number of stakeholders within Oregon Health Authority to share the learnings and to ensure they were considered in the health reform and early learning system redesign efforts.
- During the course of the ABCD III effort, developmental screening rates have increased (see Figure 5).
- Five of the eight MCOs who participated in ABCD III have chosen to continue work in this area through their current External Quality Review efforts. Based on their request, OPIP has met with each of these entities to provide guidance and input on their next phase of work.
The findings from the ABCD III effort stimulated and informed ongoing support for a measure of Developmental Screening in the CHIPRA Core Measurement that is part of federal efforts within the Centers for Medicare and Medicaid Services.

- The fact that the Developmental Screening is in the Core Measurement Set and the state has had experience with the ABCD III effort was influential in the selection of Developmental Screening as an incentive metric for the Coordinated Care Organizations.

Over the course of the project, participating MCOs took various approaches to address the objectives of the ABCD III project. These approaches ranged from system-level interventions to assisting practices at the ground level. Table 1 below outlines the categories of work undertaken by each of the corresponding MCOs.

Table 1: Overview of Improvement Strategies Used by the ABCD III MCOs

<table>
<thead>
<tr>
<th>Improvement Strategies Used</th>
<th>Kaiser</th>
<th>MPCHP</th>
<th>Prov</th>
<th>ODS</th>
<th>Lipa</th>
<th>DCIPA</th>
<th>CareOR</th>
<th>THA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide ASQ</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>ASQ Reminders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
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</tr>
<tr>
<td>Telephone Interviews</td>
<td></td>
<td>X</td>
<td></td>
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<tr>
<td>START Training</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Referral Follow-up</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>1</td>
</tr>
<tr>
<td>Clarify/Detail Policies</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Provider Website</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Member Website</td>
<td>X</td>
<td>X</td>
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<td>Member Mailings</td>
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<tr>
<td>Referral Form Detailing</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Referral Form- EHR</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Peds Care Manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>2</td>
</tr>
<tr>
<td>EI/Practice Coordination</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Coordination w/CaCoon</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>
**Tri-State Children’s Health Improvement Consortium (T-CHIC):**

OPIP has the privilege of being a partner on the Tri-State Children’s Health Improvement Consortium (T-CHIC). The Tri-state Children’s Health Improvement Consortium is an alliance between the Medicaid/CHIP programs of Alaska, Oregon, and West Virginia, formed with the goal of markedly improving children’s health care quality. OPIP is currently in the fourth year of this five-year contract with T-CHIC, and OPIP is a partner with the Child and Adolescent Health Measurement Initiative (CAHMI) on this work.

Through T-CHIC, OPIP has the opportunity to work collaboratively on quality measurement and improvement activities that engage three different state Medicaid/CHIP agencies, four non-profit organizations, and 21 front-line practice sites (11 composed primarily of family medicine physicians). See Figure 6 below.

**OPIP’s role across T-CHIC efforts is in the following four activity areas:**

**Figure 6: Overview of OPIP’s Consultation Role in T-CHIC**

<table>
<thead>
<tr>
<th>Activity #1: Consultation and Assistance on Project Planning and Implementation Across T-CHIC, Coordination of T-CHIC Grant Level Activities, Required Activities of All-Demonstration Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms. Reuland serves on the leadership team for the Tri-State effort and helps to strategically plan and address the collaborative goals.</td>
</tr>
<tr>
<td>As part of this effort, Ms. Reuland works with the National Evaluator to address their informational needs about the applied measurement, improvement and policy level-learnings across the tri-state project.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity #2: Learning Curriculum and Collaborative Across the T-CHIC States</th>
</tr>
</thead>
<tbody>
<tr>
<td>An integral component of the T-CHIC effort is to facilitate a “Learning Collaborative of Collaboratives” that are occurring across the three states and a Learning Curriculum to support across state learnings, to provide comparative data about the states to motivate and inform improvement learnings and generate across T-CHIC innovation.</td>
</tr>
<tr>
<td>OPiP plays a central role in T-CHIC in developing the Learning Curriculum and supporting the facilitation and development of the Learning Collaborative process in order to address key issues.</td>
</tr>
<tr>
<td>OPiP leads the facilitation of the collaborative efforts focused on medical home quality improvement and also leads the Learning Collaborative call of the 21 front-line practices sites across the three states.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consultation on Data Collection and Reporting of the CHIPRA Core Measures.</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPiP is providing general consultation on the State Medicaid/CHIP use of the core measures and the practice-level collection of the topics addressed by the core measures.</td>
</tr>
<tr>
<td>OPiP is also focusing specific efforts on the measures related development screening, patient experience of care surveys (CAHPS® HP CCC and CAHPS® CG PMCH), and stratification of the measures by children and youth with special health care needs.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Home Quality Improvement, Measurement and Evaluation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPiP is responsible for designing the Medical Home Office Report Tool (MHORT) and the implementation processes, and for analyzing, reporting and use of the data to guide practice, state, and across T-CHIC improvement efforts.</td>
</tr>
<tr>
<td>OPiP is also responsible for facilitating the development of memos that summarize and distill the learnings from the practice-level work into inform policy-level improvements.</td>
</tr>
<tr>
<td>OPiP also has provided targeted technical assistance and coaching the Alaska partners on how to design their Learning Collaborative and Learning Curriculum and provided targeted quality improvement coaching to specific Alaska sites.</td>
</tr>
</tbody>
</table>
Highlights of Key T-CHIC Activities and Learnings Related to Measurement and Improvement:

**Highlight of Activities #1 and #2: T-CHIC Leadership and Curriculum**

- OPIP led the development of the Year 4 T-CHIC learning curriculum and related monthly calls.
- T-CHIC held a successful two-day meeting of the project partners in June 2013. OPIP played a key role in the design of the meeting and facilitated a number of sessions meant to leverage and use the medical home data collected to inform the improvement efforts at the state and practice levels, and strategic assessment of the CAHPS® CG PCMH as compared to the Medical Home Office Report Tool (MHORT).
- Ms. Reuland represented T-CHIC on the CMS sponsored webinar for all of the CHIPRA Demonstration Grantees. The April 2013 webinar was titled “Family and Professional Partnerships: A Cornerstone of Medical Home Transformation Efforts”. National webinar sponsored by CMS for the CHIPRA Demonstration Grantees and key partners” and was conducted in partnership with the Oregon Center for Children and Youth with Special Health Needs.
- The abstract, submitted by T-CHIC and Ms Reuland serving as the lead author, titled “Becoming Better Medical Homes: Improving Systems and Processes in the Tri-State Children’s Health Improvement Consortium (T-CHIC)” was accepted and presented at the AcademyHealth - Child Health Services & Research (CHSR) Meeting. The poster presentation described the positive impact T-CHIC has had on improving quality of care for children and adolescents, and the variations in quality observed between the tools used and by practice characteristics.

**Highlights of Activity #3: Consultation & Support on Work Related to the CHIPRA Core Measures**

*Measures of Developmental Screening*

Ms. Reuland serves as the measure steward for the CHIPRA Core Measure on Developmental Screening in the First Three Years of Life.

- Ms. Reuland submitted the paperwork to maintain National Quality Forum endorsement of the measure.
- In June 2013, Ms. Reuland led the development and facilitation of a webinar sponsored by CMS and Mathematica Policy Research titled “Developmental Screening in the First Three Years of Life: Innovative State Approaches to Collecting, Reporting, and Using the Measure to Improve Care”. Charles Gallia, PhD from the Oregon Health Authority co-presented on the range of efforts in the state that leverage the CHIPRA core measure on developmental screening. In addition, spotlights were provided by Maine, South Carolina, Connecticut, Arizona, and Alaska (a T-CHIC partner).

- **Technical Assistance to Practices on Billing for 96110.**
  - The CHIPRA core measure on developmental screening includes specifications anchored to the claims data and use of the 96110 claim.
  - Through OPIP’s work with the T-CHIC practices, it is clear that there is a lack of uniformity in the use of 96110 and confusion amongst practices about how it can be used and what may be applicable modifiers.
    - OPIP developed a presentation with related resources and materials to coach practices on using the 96110. OPIP had conducted one-on-one technical assistance on applying the information described in this packet with a number of practices.
  - OPIP also provided consultation to the Alaska T-CHIC partners in Medicaid/CHIP around potential policy-level clarifications that may be needed to support the use of 96110.
CAHPS© CG PCMH
- The CAHPS© Clinician and Group Patient Centered Medical Home (CAHPS© CG PCMH) survey was administered across the T-CHIC Practice Sites. DataStat provided the T-CHIC project, state, and practice teams with general reports highlighting the findings.
- The OPIP team led specific analyses aimed to identify HOW the findings could be used to enhance the T-CHIC Learning Curriculum and to practice-level facilitation efforts.
- OPIP also led analyses that compare and contrast the “quality story” told between the CAHPS© CG PCMH and the office reported tools.
  - To date, OPIP has disseminated these strategic reports and the implications to the T-CHIC project staff, state-specific reports to the project-level teams, and practice-level reports to the applicable practices.

Highlights of Activity #4: Medical Home Quality Improvement, Measurement, and Evaluation

Learning Collaborative Calls Across the 21 Practice Sites Participating in T-CHIC
- A key goal of T-CHIC is to have the practices across the three states learn from each other in the medical home transformation effort.
- OPIP helps to support this in two ways:
  1. Development and Facilitation of Learning Collaborative Calls of the 21 Practice Sites
     - Three calls are held each year.
     - The calls are designed to provide an overview of a shared area of focus across the T-CHIC practices, provide specific tools and strategies that can be used by practices, and then to spotlight innovation within the T-CHIC practices through practice-level presentations. The practices are then encouraged to ask each other questions in order to build off and learn from each other.
   - During this report period the calls were focused on:
     - Hearing and Learning from Practice-Level Innovation Focused on Care Coordination for Children & Youth
     - Patient Experience of Care Surveys: Harnessing the Power of Patient Input
  2. Development and Reporting of the T-CHIC Medical Home Priority Tracking Sheet
     - T-CHIC recognized that medical home is quite a broad concept. OPIP led a process by which the MHORT data, collected in Spring 2012, was used to identify priority areas where the largest gaps existed between recommended care and what was being provided. Additionally, the T-CHIC partners identified areas of importance based on the literature, and their importance as Medicaid/CHIP level activities and children and youth (see Figure 7).
As a result of these efforts, OPIP created the **T-CHIC Medical Home Priorities** checklist. The purpose of this tool is to hone in the T-CHIC activities to specific areas, and to create meaningful indicators that would gauge the T-CHIC efforts.

- There are indicators at the state project team level and at the practice-level.
- Data is collected every 6 months relative to these indicators. OPIP then feeds this information back to the T-CHIC team, state-partners, and practices so that it can be used to gauge efforts and identify Learning Curriculum opportunities.

**Innovative Strategies for Enhancing Medical Home for Children and Youth**

- Identification of children and youth with special health care needs (CYSHCN) has been identified as a shared priority for T-CHIC. OPIP led the development of an “**Innovation Brief**” on methods and strategies practices can use to identify children and youth with special health care needs. The brief includes vignettes from various T-CHIC practices, with examples of applied methods they have used.

- Care Coordination is also a shared priority for T-CHIC. One tool to enhance care coordination is the use of **Shared Care Plans**. OPIP led the development of an “**Innovation Brief**” on what a shared care plan is, and provided examples of shared care plans and methods practices can use to implement a shared care plan. The brief includes vignettes from various T-CHIC practices with examples of applied methods they have used.

**Office Reported Tools of Medical Home: Medical Home Index Revised Short Form & National Committee for Quality Assurance PCMH 2011**

- OPIP leads the analysis of T-CHIC Medical Home Office Report Tool (MHORT) collected at baseline across all 21 practices participating in the medical home improvement efforts and every six months.
  - Thanks to collaboration with the T-CHIC partners, the baseline data and two follow-up data collections have been conducted to gauge and assess T-CHIC progress, and identify areas of focus within the T-CHIC Learning Curriculum and opportunities for enhanced practice facilitation.
  - With each round of collection, OPIP creates over 30 individual reports that are targeted to specific audiences including federal CMS, T-CHIC overall, each state team, and the 21 practice sites participating in the T-CHIC effort.
Enhancing Child Health in Oregon (ECHO) Medical Home Learning Collaborative:

OPIP continues its collaboration with the Oregon Rural Practice-based Research Network (ORPRN) in conducting the ECHO Medical Home Learning Collaborative, which is completing its second year. This learning collaborative is working with eight practices across the state of Oregon as they work to implement medical home principles into their clinic structures and operations, as well as individual patient-provider interactions. Additionally, OPIP is partnering with the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) on the ECHO project. OCCYSHN provides valuable guidance and technical assistance on the curriculum and practice-level coaching specific to care coordination for children with special health care needs and parent professional partnerships within the practices and across the overall project.

The goals of the ECHO Learning Collaborative:
1. Assist practices in implementing components of a medical home for children and youth, as articulated in the standards of the Oregon Patient-Centered Primary Care Home (PCPCH).
2. Identify and support meaningful systems and change processes that primary care homes can implement to achieve the standards in the PCPCH for children and youth.
3. Identify and categorize the challenges and barriers at the practice level in achieving the goals of the PCPCH Standards, and evaluate the practice’s experience of care and of implementation of the PCPCH Standards.
4. Identify specific PCPCH measures (either existing or newly developed concepts implemented in the Learning Collaborative) that achieve the goals articulated in the PCPCH standards.
5. Develop a community and targeted process by which primary care homes can learn from each other about innovative care systems.
6. Create a manual of implementation guidelines and recommendations for Pediatric and Family Medicine practices, across a diverse range of clinic settings, who are interested in achieving the PCPCH standards.
7. Assess the impacts of Medical Home / PCPCH designation on patient outcomes, including patient experience of care.

OPIP leads the development of the ECHO Learning Curriculum, which is comprised of in-person, day long Learning Sessions every six months and monthly learning collaborative calls. The calls provided content specific training related to aspects of medical home and allow practices to share and learn from each other in their improvement work. The subjects of the five ECHO earning sessions are:
- Identification of Children and Youth with Special Health Care Needs (CYSHCN)
- Care Coordination
- Behavioral Health Integration
- Family-Professional Partnerships
- Sustaining Change

The third and fourth learning sessions were conducted in November 2012 (Behavioral Health Integration) and May 2013 (Family-Professional Partnerships).

Highlights of Key ECHO Activities and Learnings Related to Measurement and Improvement:

- All of the practices continued work from the first two learning sessions – Identification of CYSHCN and Care Coordination. These two topic areas were incredibly dense for the practices, so considerable practice effort continued in these two areas. The bulk of the work conducted by practices has focused on the implementation of Shared Care Plans, developed jointly with the
care coordinator and the patient or family. Work has continued on the ongoing identification of CYSHCN.

- The third ECHO learning session was held in November of 2012, and covered Behavioral Health Integration. David Pollack, MD from OHSU gave the keynote address. This was chosen as a subject because it expanded on the concepts of identification of CYSHCN and Care Coordination by enhancing primary care providers’ skills in identification, and first-line management of children and adolescents with mental health and behavioral concerns. This subject area is also in alignment with the AAP’s policies around mental and behavioral health integration at a primary care practice level.

- The fourth learning session was held in May 2013, and covered Family-Professional Partnerships within primary care. Presentations were made by parents, the Novel Innovations in Child Health (NICH) program, and Patty Vega, RN from the Oregon Care Coordination Program (CaCoon) which is Oregon’s public health home visiting nursing program. Additional content was delivered in conference calls on engaging parents and families in QI efforts.

Of the eight sites participating in the ECHO Learning Collaborative, OPIP is providing the hand-on support and coaching for five practices.

Table 2 below provides a high-level summary of the quality improvement and transformation activities conducted by the five sites OPIP is responsible for facilitating.

**Table 2: OPIP ECHO Practice Improvement Activities**

<table>
<thead>
<tr>
<th>Practice Improvement Strategies</th>
<th>CHAoS</th>
<th>FMG-NE</th>
<th>Hillsboro</th>
<th>Children’s Clinic</th>
<th>Woodburn</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Career Coordination</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attested to PCPCH</td>
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<td>X</td>
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<tr>
<td>Implemented the CSHN Screener</td>
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<td>X</td>
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<tr>
<td>Can identify CYSHCN in EMR</td>
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<td>X</td>
<td>X</td>
<td>X</td>
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<td>5</td>
</tr>
<tr>
<td>Patient’s Experience of Care</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Conducted CAHPS® CG PCMH</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Designed a QI project to improve CAHPS® CG scores</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>5</td>
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<tr>
<td>Patients in QI</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hosted Focus Group(s)</td>
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</tr>
<tr>
<td>Added Patients to QI Team</td>
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<td>2</td>
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<tr>
<td>Created Steering Committee</td>
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<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Behavioral Health Integration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening adolescents for depression</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>5</td>
</tr>
<tr>
<td>Screening adolescents for substance abuse</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>5</td>
</tr>
<tr>
<td>Co-located</td>
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<tr>
<td>Self-Management Support</td>
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<td></td>
</tr>
<tr>
<td>Working to identify barriers to care</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<td>2</td>
</tr>
<tr>
<td>Working to set patient centered goals</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>5</td>
</tr>
<tr>
<td>Quality Improvement Infrastructure and Processes</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>5</td>
</tr>
<tr>
<td>Created a QI team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formal Process to review QI project Management</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>5</td>
</tr>
</tbody>
</table>
Examples of Practice-Level QI Efforts

- **The Children’s Clinic (TCC)** revised a long-standing adolescent screener that had been used in the practice for well-visits over the age of 12. The previous version of the form had general questions about mental health and substance use, but did not include any specific validated screening tools. The new screener incorporated the PHQ2 and CRAFFT screeners. This was implemented in the practice in late 2012, and was shared with the other practices in the ECHO Learning Collaborative. All of the other practices have explored the implementation of this tool. TCC also developed EMR forms that provide decision support for depression screening and substance use/abuse screening. This form automatically pulls up the PHQ9 depression tool when the PHQ2 (considered a brief, or pre-screener) is positive. This allows providers to move from screening to diagnostic tools seamlessly.

- **Family Medical Group Northeast** participated in the dissemination of the CAHPS© CG PCMH survey and was able to distribute surveys to both the adult and child populations. Upon examination of their overall scores, it was revealed that their access domain was lower than the state average. To better understand why patients felt this way, the practice further surveyed their patient population on more specific matters around access and then hosted a focus group to hear from those patients. The focus group was made up of four practice members of different demographics including a patient who is also a mother of a child who is seen at the practice, an elderly woman, and a mother of an older child with special health care needs. The group was able to provide great insight into the topic and provided Family Medical Group with some ideas that the practice will now begin to pilot to see if their overall scores improve in their next CAHPS© survey.

- **Childhood Health Associates of Salem** had expressed interest in involving patients in their practice’s quality improvement since the beginning of the Learning Collaborative, but weren’t sure about where to start. After learning about key concepts and considerations through involvement with ECHO, they hosted their first Medical Home Steering Committee meeting in June 2013. It is their hope that this group can be used as a platform to run quality improvement ideas by families before implementation, to have parents review materials to ensure that they are family-centered, and to help provide further insight into their patient population. The group is made up of Childhood Health staff from every department and five families with different backgrounds, including parents of children with special health care needs, a foster parent, and a parent of adolescent children. At their first meeting they reviewed their CAHPS© CG PCMH results and identified actionable ways to improve their access scores for children and youth with special health care needs. Since that meeting, the practice has implemented a process for an advanced check-in process for patients with special health care needs, so parents have fewer administrative forms to fill out prior to their visits (they still may have developmental screeners, but no insurance or demographic forms), and the care coordinators call this population prior to visits to conduct pre-visit preparation to better understand the family’s needs for the appointment. Initial feedback since implementation of the pre-visit calls has been overwhelmingly positive from both the parents and the providers.

- Seven of the eight practices in the Learning Collaborative participated in the fielding of the CAHPS© CG PCMH patient survey. The survey was administered with the addition of several questions that helped to flag CYSHCN so that the results could be stratified by this important, vulnerable population. Results have been shared back to the practices, and practices are beginning to consider how to implement the results into their quality improvement efforts.
Demonstrated Improvements in Care in the ECHO Sites

Across the sites, improvements have been observed on the quality domains within the MHI-RSF© and the NCQA PCMH® 2011. Change was also seen between baseline and Spring 2013.

- The MHI-RSF© assesses improvement efforts specifically targeted to children and youth with special health care needs (CYSHCN). Figure 8 provides the quality domain level improvements observed. The most improvement between Baseline and Spring 2013 was observed in the quality domain related to Community Outreach (+10.9%) and Care Coordination (+10.4%). Individual, practice-based improvement efforts observed in this area were family feedback, identification of CYSHCN, care coordination, and engaging families and assessing their needs.

All practices hired a care coordinator or ensured that practice-based care coordination functions were identified and assigned to specific persons within the practice; however, one practice lost their care coordinator in Winter of 2012-13. In Oregon, the practices financially supported their care coordinators internally.

- Improvements were also observed on scores to the NCQA PCMH®, which looks more globally at patient-centered medical homes for all patients. The most change was observed in the domains related to Community Outreach (+10.9%) and Care Coordination (+10.4%).

- It is important to note that the improvement opportunities identified and the relative rank of the practice-level scores often varied significantly between the MHI-RSF© and NCQA PCMH®. While both are focused on the concept of medical home, the specific focus on CYSHCN and related needs for this population yielded different observations about the quality of care provided and improvements observed.
Patient Centered Primary Care Institute (PCPCI): Activities for Which OPIP Is Involved:

The Patient Centered Primary Care Institute (www.pcpci.org) seeks to bring together technical experts, health care providers and staff, patient advisors, policymakers, academic centers, and others to gather and share valuable practice transformation knowledge and resources. OPIP is working with PCPCI in various ways to address our synergistic objectives with regard to transformation across the healthcare system, ranging from the practice to the policy level.

- **Technical Assistance Expert Learning Network**: In an effort to build capacity for statewide primary care transformation, the PCPCI brings together professionals who support practices as they work toward the primary care home/medical home model of care. OPIP participates in this network, which is designed to allow these entities to share successful strategies with regard to quality improvement and primary care transformation.

- **Webinar and Train-the-Trainer**: OPIP has also participated as a trainer on PCPCI webinars. These regular webinars are for any and all who are interested in participating, and include a wide range of topics related to primary care transformation. Additionally, PCPCI seeks to provide opportunities for “train-the-trainer” type activities. In our areas of expertise and experience we will partner with the PCPCI in this way.

- **Medical Home Learning Collaborative**: A significant part of our work with the PCPCI is facilitating a medical home learning collaborative of five urban and rural pediatric primary care practices that represent a diversity of sizes and geographic regions in Oregon:
  - Olson Pediatrics; Lake Oswego
  - Treasure Valley Pediatrics; Ontario
  - Westside Pediatrics; Portland
  - Sanford Pediatrics; Klamath Falls
  - Bay Clinic Pediatrics; Coos Bay

Through face to face Learning Sessions, Webinars, and at-the-elbow support in the form of Practice Facilitation and Coaching, OPIP is working with participating practices to build internal capacity for transformation, and improve as patient centered medical homes.

**Learning Sessions, Webinars, Shared Online Workspace**

Using a modified version of the Institute for Healthcare Improvement’s Breakthrough Series Learning Collaborative model, OPIP brings participating practices together for a series of face to face learning sessions. These full day sessions always highlight the importance of partnering with parents and being patient centered in medical home approaches. Each includes presentations and educational opportunities on specific content areas related to medical home transformation, as well as time to interact and share learnings with peers, and facilitated time to plan for the transformative work each site will undertake upon returning to their practice.

Webinars are used to bring sites together in a virtual environment between Learning Sessions. Here, sites present and discuss progress, successes, and barriers with their peers. Additionally, short didactic sessions on areas of shared interest and focus across the sites are presented and discussed. These webinars allow for collaboration and continued momentum between face to face learning sessions.

OPIP also provides and supports the use of a shared online workspace (QI Teamspace). Here, sites can access learning collaborative resources and materials, and coordinate and collaborate with their own project team and teams from other sites.
Practice Facilitation and Coaching

OPIP provides practices real-time, on the ground support through Practice Facilitators (see Appendix B). These individuals work to understand the unique dynamics of each practice, and use this information, with a strength-based approach, to provide what is needed to move toward improvement. This includes assessing practice workflows and processes, quality improvement coaching and planning, and connection to technical assistance and content experts. Additionally, a key role for the facilitator is to connect practices to peers within and separate from the collaborative in order to encourage and support shared learning. Facilitators visit practices monthly and communicate regularly to foster improvement over the course of the project.

Highlights of Key PCPCI Activities and Learnings Related to Measurement and Improvement:

Table 3 provides a high-level summary of the quality improvement and practice transformation efforts conducted by the practices that are part of the PCPCI Pediatric Learning Collaborative that OPIP has provided practice facilitation.

Table 3: OPIP PCPCI Practice Improvement Activities

<table>
<thead>
<tr>
<th>Practice Improvement Activities</th>
<th>Olson Pediatric Clinic</th>
<th>Westside Pediatric Clinic</th>
<th>Treasure Valley Pediatric Clinic</th>
<th>Bay Clinic Pediatrics</th>
<th>Sanford Children's Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attested to PCPCH</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Will be attesting in Jan ’14 to updated standards</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality Improvement Skills/Processes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve QI infrastructure</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Establish (or Improve) QI Committee/Team</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Bright Futures Recommendations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement recommended screenings</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Care Coordination</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have a Care Coordinator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modify care-coordination roles within current team</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Identification of children with special healthcare needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modify process for referral tracking</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Shared Care Plan development</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient's Experience of Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conducted CAHPS© CG PCMHH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Utilize/Review CAHPS© data previously collected</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Designed a QI project to improve CAHPS© CG scores</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Examples of Practice-Level QI Efforts

- **Bay Clinic Pediatrics:** The focus of Bay Clinic’s quality improvement work for this project has been the administration of a patient experience of care survey, namely the CAHPS© CG PCMHH including the CAHMI CYSHCN Screener. OPIP assisted Bay Clinic in the personalization and development of the survey tool itself (paper version and SurveyMonkey) and accompanying provider specific cover letters. Additionally, OPIP assisted in the development of scripts for providers and medical assistants, posters for the waiting room and exam rooms, as well as post cards with web-link for dispersal. OPIP facilitators have also helped Bay Clinic to develop a multi-phased quality improvement plan for utilizing their CAHPS© data.
- **Sanford Children’s Clinic**: Sanford Children’s Clinic focused initially on implementing the two Bright Futures recommended sensory screenings (hearing and vision) at the four and five year visits. In order to accomplish this, they made improvements to their quality improvement processes, and have since established an official QI Committee that includes all interested staff from the practice. As part of the effort to improve recommended screenings, they utilized public displays of run chart data, and held competitions among the nursing staff to encourage progress toward the goal. They have now held steady at 95% or above in completing both screenings at the appropriate visits.

- **Treasure Valley Pediatric Clinic**: Treasure Valley Pediatric Clinic initially focused on improving care for ADHD patients seeking to improve visit rates for those with a diagnosis and prescription, and also to improve the number that had a completed parent questionnaire. After exceeding their goal in the first action period, Treasure Valley moved to implement and pilot team based care. This included activities related to empanelment as they were not previously empanelled. They are currently still empanelling patients and working to spread team based care throughout the practice.

**Demonstrated Improvements in the OPIP PCPCI Pediatric Learning Collaborative**

As this project is still in progress, follow up data collection has yet to occur. A primary objective for this Pediatric Learning Collaborative is for practices to attest to Oregon’s Patient Centered Primary Care Home Program (all of the sites hadn’t previously attested). As shown in Figure 9 below, the OPIP PCPCI Pediatric Learning Collaborative sites have been successful in this effort. While all sites are prepared to attest, those who haven’t have been asked by the Oregon Health Authority to delay attestation until the new standards take effect in January 2014.

**Figure 9: Oregon PCPCH Status for Oregon PCPCI Sites**

![Graph showing percentage of PCPCI Pediatric Learning Collaborative Practices that are PCPCH certified](image)

*The Oregon Health Authority has requested that two PCPCI practices delay their attestation for PCPCH certification until January 2014*
Activity #2: Supporting Evidence-Guided Quality Activities in Clinical Practices

General Overview
One of the fundamental components of the OPIP mission statement is the implementation of evidence-guided improvements in clinical practices. Each of the four current projects within OPIP is focused on the implementation of evidence-based guidelines, related developmental screening, and medical home. Furthermore, the projects are also addressing components of the guidelines for which further evidence is needed, and on-the-ground implementation and the related learnings to inform the evidence-based guidelines are being gathered.

Figure 2 (see page 6) provides an overview of the specific evidence-informed topics that OPIP has developed, or worked with partners to develop related training and education materials. These presentations, conducted either through in-person learning sessions or webinars, are an integral strategy for how OPIP provides coaching and applicable tools and strategies for addressing the evidence-informed topic.

Project-Specific Highlights

Assuring Better Child Health and Development-III (ABCD III):
OPIP developed the ABCD III PIP infrastructure and expectations, and ensured that the four goals of the PIP were aligned with the evidence-base around screening, referral, and care coordination. Over the course of the last year, OPIP has presented and regularly reinforced elements of the Bright Futures recommendations, including the evidence-based clinical guidelines around standardized developmental screening with a validated tool at recommended periodicities. Figure 10 below provides a high-level summary of key topics addressed in the Learning Collaborative. As a result, many of the MCOs clarified internal processes and policies around these recommendations, and also communicated with contracted providers about both the expectations and reimbursement procedures for carrying them out. Additionally, a few plans have worked with practices around improving processes for referring to and coordinating with Early Intervention (EI).

Figure 10: July ‘12-July ‘13
ABCD III Meetings

<table>
<thead>
<tr>
<th>ABCD III Calls and In-Person Sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>August 2012- Individual Meetings/Calls With Participating Managed Care Organizations (MCOs)</strong></td>
</tr>
<tr>
<td>• Assessment and discussion of MCO progress over the duration of ABCD III</td>
</tr>
<tr>
<td>• Plans and expectations for the remaining two months</td>
</tr>
<tr>
<td>• Feedback and evaluation of the Oregon Pediatric Improvement Partnership and the overall Performance Improvement Project (PIP) process.</td>
</tr>
<tr>
<td><strong>September 10th 2012- MCO Learning Community Meeting- Salem, OR</strong></td>
</tr>
<tr>
<td>• Review ABCD III PIP goals</td>
</tr>
<tr>
<td>• Peer learning- MCO report out, status update, Q&amp;A</td>
</tr>
<tr>
<td>• Overview of final External Quality Review Organization assessment structure</td>
</tr>
<tr>
<td>• Requirements for spread and sustainability plans</td>
</tr>
<tr>
<td><strong>October 8th 2012- MCO Learning Community Meeting- Salem, OR</strong></td>
</tr>
<tr>
<td>• Review ABCD III PIP goals</td>
</tr>
<tr>
<td>• Review ABCD III chart audit data findings</td>
</tr>
<tr>
<td>• Review and discuss spread and sustainability plans</td>
</tr>
<tr>
<td>• Peer learning- MCO report out, status update. Q&amp;A</td>
</tr>
</tbody>
</table>
TriState Children’s Health Improvement Consortium (T-CHIC):

As was described earlier, the T-CHIC efforts are focused on supporting evidence-guided quality activities in clinical practices via two main methods:

1. Practice-based improvement efforts focused on medical home transformation.
2. Collection and, more importantly, use of the CHIPRA core quality measures to understand the quality of care provided, and to use the information collected, when relevant and applicable, to improve care.

Figure 11 below highlights content areas within the T-CHIC Learning Curriculum that OPIP has developed educational and facilitation materials.

<table>
<thead>
<tr>
<th>Learning Collaborative Calls Across All of T-CHIC Facilitated by OPIP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>September 2012</strong></td>
</tr>
<tr>
<td>• T-CHIC Use of QI Teamspace</td>
</tr>
<tr>
<td><strong>November 2012</strong></td>
</tr>
<tr>
<td>• T-CHIC Care Coordination: Core aspects identified, current strengths and strategies, related tools and resources, health policies that can support these efforts</td>
</tr>
<tr>
<td><strong>December 2012</strong></td>
</tr>
<tr>
<td>• Updated MHORT Data: What did we learn about innovative improvements going on in T-CHIC. Update on strengths and areas for improvement.</td>
</tr>
<tr>
<td><strong>April 2013</strong></td>
</tr>
<tr>
<td>• Medical Home Innovation: Spotlight of innovative and exciting improvement work in the practices and policy level implications; Overview of potential analytic plan for comparing and contrasting the “medical homes” story told by the various data sources</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Annual In-Person T-CHIC Meeting: Sessions Facilitated by OPIP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>June 2013</strong></td>
</tr>
<tr>
<td>• T-CHIC Medical Home Transformation Efforts – Review of the Data (Overview of the MHORT Spring Findings &amp; T-CHIC Priority Findings and Key Areas of Strengths, Improvement, and Areas Needing Focus. Included presentation of data related to practice-level characteristics associated with higher quality and improvement)</td>
</tr>
<tr>
<td>• CAHPS® CG PCMH Comparison of the data told by CAHPS® CG PMCH vs. MHORT. Similarities and Differences and Implications for Improvement Efforts. Proposed future analytic plan and brainstorming session with group about analyses of interest.</td>
</tr>
<tr>
<td>• T-CHIC MH Transformation Efforts in the Next Year: How do we Ensure That We Are Able to Tell The “Story” of What We Learned</td>
</tr>
<tr>
<td>• Family-Professional Partnership: What does it mean to families?</td>
</tr>
<tr>
<td>• T-CHIC Medical Home Priorities – Assessing where we are now, what we have learned, and opportunities for a focus in the next year</td>
</tr>
<tr>
<td>• Oregon’s progress on T-CHIC Priorities related to Engaging Families – and Care Coordination.</td>
</tr>
<tr>
<td>• T-CHIC Learning Curriculum: 2013-2014</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Learning Collaborative Calls Of the 21 Practice Sites Participating in T-CHIC Facilitated by OPIP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>February 2013</strong></td>
</tr>
<tr>
<td>• Hearing and Learning from Practice-Level Innovation Focused on Care Coordination for Children &amp; Youth</td>
</tr>
<tr>
<td><strong>May 2013</strong></td>
</tr>
<tr>
<td>• Patient Experience of Care Surveys: Harnessing the Power of Patient Input</td>
</tr>
</tbody>
</table>
ECHo Medical Home Learning Collaborative:

A central component to the ECHO Learning Collaborative is the Learning Curriculum in which evidence-informed and practical primary care based tools and strategies are detailed for the practices. The curriculum intentionally addresses specific aspects of medical home, and has been anchored to areas identified as needing focus based on the baseline and periodic data collections of the MHORT. Figure 12 below provides an overview of the topics addressed during this annual report period.

**Figure 12: July ’12-July ’13**

<table>
<thead>
<tr>
<th>ECHO Learning Curriculum Topics Addressed</th>
<th>In-Person Learning Sessions</th>
<th>Learning Collaborative Calls</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>November ’12 Learning Session- Integrating Behavioral and Mental Health into Primary Care</strong></td>
<td>• Examining the Medical Home Office Report Tool: What have we learned? What are the opportunities for improvement?</td>
<td>July 12th 2012</td>
</tr>
<tr>
<td>• Behavioral Health Integration* (full presentation by David Pollock)</td>
<td></td>
<td>• Teamness</td>
</tr>
<tr>
<td>• From the eyes of a parent: The impact of non-integrated care* (full presentation by Shelley Barnes)</td>
<td></td>
<td>August 9th 2012</td>
</tr>
<tr>
<td>• Practice Readiness Assessment for Behavioral Health Integration</td>
<td></td>
<td>• Shared Care Plans</td>
</tr>
<tr>
<td>• Overview of the Oregon Pediatric Society Mental Health Taskforce and Opal K* (full presentation by Tami Pettersen)</td>
<td></td>
<td>September 13th 2012</td>
</tr>
<tr>
<td>• Practice Tools and Resources to Screening for Behavioral Health Issues in Primary Care</td>
<td></td>
<td>• Referral Tracking and Management</td>
</tr>
<tr>
<td><strong>May ’13 Learning Session – Tools and Methods to Enhance Family &amp; Professional Partnership</strong></td>
<td></td>
<td>October 11th 2012</td>
</tr>
<tr>
<td>• Examining the Medical Home Office Report Tool: What have we learned? What are the opportunities for improvement?</td>
<td></td>
<td>• Patient Engagement in Quality Improvement</td>
</tr>
<tr>
<td>• Power of the CAHPS® CG PCMH Quality Data About Patient Experiences, Levels of Communication and Impact on Family and Professional Partnership</td>
<td></td>
<td>December 13th 2012</td>
</tr>
<tr>
<td>• Framing The Goals For The Next Action Period On Patient Engagement/Family-Professional Partnership</td>
<td></td>
<td>• Family Risk Assessment: Screening for Peripartum Mood Disorders</td>
</tr>
<tr>
<td>• Family-professional Partnership: What Does It Mean To Me And How Can We Partner Best Together* (Presentation By Shelley Barnes And Tami Montemayor)</td>
<td></td>
<td>January 10th 2013</td>
</tr>
<tr>
<td>• Tools And Strategies For Engaging And Partnering With Patients And Families: Lessons From Healthcare Providers In The NICP Program *(Presentation By Matthew Herwood)</td>
<td></td>
<td>• Medical Home: Essential Components for Children Exposed To Violence</td>
</tr>
<tr>
<td>• Tools And Strategies For Partnering With Families: Lessons From Community Based Home Visiting Nurses *(Presentation By Patty Vega, RN)</td>
<td></td>
<td>January 23rd 2013</td>
</tr>
<tr>
<td>• Practice Tools And Resources</td>
<td></td>
<td>• Update Process To The PCPCH Program In 2014</td>
</tr>
<tr>
<td><strong>Behavioral Health Integration</strong></td>
<td></td>
<td>February 14th 2013</td>
</tr>
<tr>
<td>• Following the learning session, all practices worked on the implementation of adolescent depression and substance abuse screening through the use of the PHQ2, PHQ9 and CRAFFT screening tools.</td>
<td></td>
<td>• PCPCH Update Feedback and Practice Report Cuts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>March 14th 2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Overview of CAHPS® CG PCMH Data To Track Improvements</td>
</tr>
<tr>
<td></td>
<td></td>
<td>April 11th 2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Oregon Health Reform Efforts and Related Practice-Based Tools</td>
</tr>
<tr>
<td></td>
<td></td>
<td>July 11th 2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Health Literacy in the Medical Home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>August 8th 2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Adolescent SBIRT and CRAFFT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>September 12th 2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• CAHPS® Facilitation and Practice Report Out</td>
</tr>
<tr>
<td></td>
<td></td>
<td>October 10th 2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medical Home Billing Support, and CAHPS® Facilitation</td>
</tr>
</tbody>
</table>

**Family and Professional Partnership**

- This is a central focus of the ECHO sites in their medical home efforts. The results from the MHORT and CAHPS® CG PCMH data support this as an area of work ripe with opportunity for improvement. Following this learning session, which had a focus on supporting self management, sites began taking first steps in involving parents and patients in quality improvement processes. The thinking is that by creating standardized protocol to involve parents and patients in the improvement process, they will develop a mechanism by which tools and strategies for partnership will be more effective and efficient, containing elements agreed upon by both providers and parents/patients. All practices expressed an interest in revisiting important tools such as shared care plans in order to make meaningful modifications. While there have been various approaches, examples include the creation of parent/patient medical home advisory committees, parent/patient focus groups, and the addition of a parent partner to the quality improvement team.
**Patient Centered Primary Care Institute (PCPCI) Pediatric Learning Collaborative:**

The PCPCI curriculum presented in the Learning Sessions and two monthly calls were focused on the presentation of evidence based tools and concepts, supporting peer to peer learning and support, and practice facilitation. Figure 13 below outlines the concepts that have been addressed to date.

![Figure 13: July '12-July '13 PCPCI Pediatric Collaborative Topics Addressed](image)

**PCPCI Practice-Level Implementation of Evidence-Informed Guidelines**

**Adaptive Reserve, Quality Improvement Infrastructure, and Practice Transformation**

- These have been topics of critical focus for this collaborative. There is a growing body of evidence that a practice’s capability to transform is dependant largely on their ability to allocate time and resources to these efforts. Additionally, all participating sites have spent a significant amount of time improving their quality improvement infrastructure, including the creation or improvement of teams.

**Bright Futures Recommended Screenings**

- Two sites have made the implementation or improvement of Bright Futures recommended screenings a focus of their medical home work. Topics have included four and five year old hearing and vision screening, and Chlamydia screening.

**Patient Experience of Care- CAHPS© CG PCMH**

- Bay Clinic Pediatrics administered the CAHPS© CG PCMH to parents and patients. This included the planning and development of materials, and the administration of the tool for a two-month period for every patient that had a visit, and planning for the use of this information for quality improvement.
**Activity #3: Incorporating the Patient and Family Voice into Quality Efforts**

OPIP is committed to incorporating the patient and family voice into quality efforts at all-levels of our organization and our project and practice-level work. We have made significant strides in this area over the past year.

**Incorporating the Patient and Family Voice into Our Organization:**

- OPIP added another patient/family representative to our OPIP Steering Committee and Partner Committee. OPIP contracted with **Alicia DeLashmutt** to serve on these committees. Ms. DeLashmutt is a parent of a child who experiences disabilities. She brings a wealth of experience as a 2007 Partners in Policy Making graduate, and is also currently working with the NWDSA Kindergarten Inclusion Cohort, Portland Public Schools (PPS) Special Education Advisory Council, PPS Special Education PTA, PPS Inclusive Education Foundation, and the OHSU Lend Program.

In addition to her role on the Steering and Partners Committee, Ms. DeLashmutt also participates on the project-level teams for the ECHO and PCPCI practices. Her role on the team is to review the Learning Curriculum materials and ensure a patient-centered orientation, and to provide feedback and guidance to the practices, from a parent perspective. An example of a role she has played on the ECHO project is reviewing and providing input to care plans developed by the practices.

**Incorporating the Patient and Family Voice into our Learning Collaborative and Learning Curricula:**

**Parents as Key Note Speakers**

- OPIP has made a commitment to have parents/youth serve as a key note speaker for every in-person Learning Session we facilitate.

- In the six in-person Learning Sessions we developed across the ECHO, T-CHIC and PCPCI efforts, there was a presentation by a parent or video vignette of interviews from multiple parents of children with special health care needs.
  - OPIP is thankful to OCCYSHN for their partnership in this effort. A majority of the parent participants were identified through OCCSYHN’s effort to connect with and train parents. We are particularly thankful to Marilyn Hartzell and Shelley Barnes from OCCSYHN in their leadership and commitment to this area.

**Training Practices on How Parents Can be Partners in Quality Improvement**

- As part of the learning curriculum for ECHO, T-CHIC, and PCPCI, OPIP has led training and educational materials for practices about how they can engage and partner with their parents on their quality improvement efforts.

- Through practice facilitation efforts, OPIP has coached a number of the practices on the implementation of some of these strategies presented including:
  1. Inviting and contracting with a parent /youth to be on the quality improvement team
     - For example, a practice participating in the ECHO Learning Collaborative (The Children’s Clinic) has hired a parent to serve on their quality improvement team.
  2. Inviting and engaging parents on the practice’s quality advisory committee.
     - For example, a practice participating in the ECHO Learning Collaborative (Childhood Health Associates of Salem) have parents on their quality improvement advisory committee.
3. Obtaining feedback from patients about their quality improvement efforts and specific tools and strategies proposed (e.g. care plans, patient portals).
   - For example, a practice participating in the ECHO Learning Collaborative (Woodburn Pediatrics) has been holding group-level meetings of their Hispanic-Latino patients to obtain feedback about their services and how they can enhance care coordination.

### SPOTLIGHT of the Patient Voice in the ECHO Medical Home Learning Collaborative

- **Data Highlighted the Need to Focus on Family Professional Partnerships:** The ECHO MHORT data on office systems and processes, and CAHPS© Clinician and Group Level survey Patient Centered Medical Home (CAHPS© CG PCMH) version showed a weaknesses in many of practices related to patient engagement, utilization of patient self-management strategies (including shared care plans, transition plans, and patient self-education), and implementation of parent advisors in QI projects and practice advisory committees.

- **Learning Curriculum and Collaborative Focus on Partnerships with Families:** Due to these shortfalls, Family-Professional Partnerships was the subject of our May 2013 learning session.
  - Practices continue their work on the implementation of shared care plans, which is intended to elicit patient strengths, goals, and barriers to treatment that are experienced by the families.
  - OPIP also developed materials for an ECHO webinar, titled “Using Patients in Quality Improvement”. This webinar reviewed principles for including patients in the quality improvement efforts at a practice level and included Shelley Barnes from OCCSYHN.
    - Nearly all of the ECHO practices have engaged their families in some form.
    - Some practices have engaged families in focus groups, while others have recruited a parent advisor to the ECHO team and to their quality improvement committees.
  - During the last project year, the practices in the ECHO learning collaborative also received their practice-level CAHPS© CG PCMH patient survey. The practices are currently working on how to interpret the results and develop quality improvement projects related to their individual survey results. This effort highlights another method for incorporating the family voice into the practices.

### Ensuring the Meaningful Use of Quality Data from Patients and Families:

Surveys completed by families/youth are an integral source of quality data. Within the ECHO, T-CHIC, and PCPCI projects OPIP has played a significant role in the meaningful collection and use of data derived from patient experience of care surveys. Specifically, across the project various versions of the Consumer Assessment of Heath System and Providers Survey© (CAHPS©) were implemented. Table 4 on the next page provides a high-level description of the various roles and responsibilities OPIP has played related to the CAHPS©.
### Table 4: Overview of OPIP Roles & Responsibilities Related to CAHPS© in T-CHIC, ECHO, & PCPCI Projects

<table>
<thead>
<tr>
<th>Roles and Responsibilities Related to CAHPS©</th>
<th>Learning Collaborative Project</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T-CHIC</td>
</tr>
<tr>
<td>Version(s) of CAHPS© Being Use in the Project</td>
<td>CAHPS© HP CCC(^1)</td>
</tr>
<tr>
<td>OPIP Role and Responsibility Related to the Use of the CAHPS© within the Project</td>
<td>Whether it is a Component of the Project, Audience for Efforts</td>
</tr>
<tr>
<td>Strategic analysis and report generation of the CAHPS© data collected</td>
<td>Yes</td>
</tr>
<tr>
<td>Use the findings from the CAHPS© data to modify the Learning Curriculum and develop Collaborative activity materials</td>
<td>YES</td>
</tr>
<tr>
<td>Consultation and coaching to practices on the administration of the CAHPS©</td>
<td>YES</td>
</tr>
<tr>
<td>Coaching and facilitation to practices on use of the data to guide improvement</td>
<td>YES</td>
</tr>
<tr>
<td>Development of briefs highlighting the implications of the findings (Specific audience targeted for briefs)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

1 CAHPS© Health Plan, Children with Chronic Conditions Module
2 CAHPS© Clinician and Group, Patient Centered Medical Home
Activity #4: Informing Policies that Support Optimal Health and Development
Project Specific Activities

Assuring Better Child Health and Development-III (ABCD III):

The work of ABCD III has illuminated various issues of significance with regard to policies supporting health and development. In fact, it is likely that some of the most impactful outcomes of ABCD III are the result of addressing just such policies and systems.

Informing Health Reform:
OPIP has held a series of meetings with leadership in the Oregon Heath Authority focused on the efforts of the Early Learning Council and Coordinated Care Organizations to ensure that learnings from ABCD III are considered. With permission from the Charles Gallia, PhD, the Principal Investigator of the project, the findings from the medical chart reviews and the MCO-level work were shared in these meetings.

Early Intervention Data System (EcWeb) Improvements
As noted in the last report, in an effort to address concerns raised during the community engagement process and by numerous stakeholders, ABCD III partners at EI designed and implemented improvements to the data system used by all Oregon EI contractors:

- **Intake script and improvements to referral fields**
  The community engagement process for ABCD III revealed that how individual contractors were interpreting the definition of certain variables in the system varied. As a result, the contractors agreed on standardized definitions and an accompanying script for intake people to follow across all contractors. This process also resulted in improved intake fields with regard to referral source, and more effectively documenting primary care provider information (regardless of referral source). Current tracking efforts show that there is enhanced input in these fields and there appears to be less variability in what and how this information is entered. This will be critical to the care coordination efforts.

- **Feedback tracking**
  Another feature added to EcWeb is the ability to track when feedback was sent to the primary care provider, what kind of feedback was sent, and to whom it was sent. This will allow for an improved tracking of coordination activities. Through an established agreement with Oregon Department of Education, OPIP is receiving monthly reports about the referrals made to EI by primary care providers AND how many primary care providers are receiving feedback from EI. It appears that referrals from PCPs have increased and that feedback to PCPs has also increased. Again, this will be a critical element to care coordination across developmental screening and services across the community and primary care based sector.
Tri-State Children’s Health Improvement Consortium (T-CHIC) & Enhancing Child Health in Oregon (ECHO):

Both of these projects are funded through the CHIPRA demonstration grant. Therefore, the learnings from these projects are meant to inform national polices from the Centers for Medicare and Medicaid Services (CMS), related to quality measurement and improvement as well as state-level public policies. Through project-level quarterly reports to the Oregon Health Authority, and the T-CHIC semi-annual reports to CMS, a number of policy level improvements and considerations have been noted.

These have been focused on:

- Policies related to enhanced reimbursement for persons with “chronic conditions” as defined by the Affordable Care Act, and how these efforts have minimized the focus on children and youth and prevention of chronic conditions, and maximal care for children with special health care needs.
- Policies related to methods used to define and identify children and youth with special health care needs.
- Policies used to define “medical home” and related payment incentives, and how to ensure a child AND family-centered focused.
  - OPIP is developing a brief that specifically summarizes the importance of office reported tools focused on children and children and youth with special health care needs given the data findings that indicate a practice can improve and score high on general tools like NCQA PCMH® and PCPCH, but may not be doing activities meeting the needs of this important population.
  - In Oregon, we are specifically developing a number of summary reports specifically focused on the improvement of the Patient-Centered Primary Care Homes efforts and related enhanced payments from Medicaid.
- Policies that require and support the use of patient experience of care data. Given this is an integral element of the Triple Aim, it is critical that patient experience of care be measured and used to gauge progress.
  - A component of this is the summary brief OPIP is creating that compares and contrast the “quality story” told by office reported tools such as NCQA PCMH® 2011, MHI-RSF© and the CAHPS© CG PCMH.
- Policy and payment considerations to support care coordination with primary care and across community-based systems serving children.
- Policies related to quality measures used at the state, system and provider-level, and implications for improvements to the measures and related processes to ensure that data collected is meaningfully used to improve care.
- Policies that can support practice-level adaptive reserve to be able to transform practice and do quality improvement and measurement activities.
- Policies that support adoption of Electronic Medical Records (EMR), tempered with an understanding about the current limitations of existing EMRs in a pediatric focus, population management, and quality measurement.

Consultation to Alaska Policy on Screening and Support:
The T-CHIC partners in Alaska Medicaid/CHIP are interested in policy-level clarifications related to standardized developmental screening. Ms. Reuland provided targeted review and feedback to the draft policy-level clarifications under development.
Activity #4: Informing Policies that Support Optimal Health and Development
Non-Project-Specific Activities Focused On Informing Oregon Health Reform Activities

Participation in OHA Workgroups/Committees:

The OPIP Executive Leadership continues its involvement in following state-led workgroups and committees that support the State’s health transformation efforts.

CCO Metrics & Scoring Committee:
The members of this workgroup were appointed by the Oregon Health Authority, as a part of the statewide efforts to oversee the operations of the emerging Coordinated Care Organizations in the state of Oregon. The specific charge of this group is to decide the quality metrics that are used for assessing the performance of the CCOs, as well as the measures associated with incentive funding. Dr. Gillespie is one of the nine appointees to this committee. Of the 17 metrics chosen for the incentive pool, several relate directly to pediatric health care, including developmental screening, adolescent well visits, and ADHD medication management. Additional measures impact all providers regardless of specialty.

PCPCH Standards Advisory Committee:
In August of 2012, the Oregon Health Authority convened the PCPCH Standards Advisory Committee, with the specific charge of reviewing the current PCPCH Standards, and deciding on new standards that will strengthen the model and encourage continued growth and improvement within primary care practices striving to become highly functioning medical homes. Dr. Gillespie is a member of this committee.

Other Committees:
Dr. Gillespie serves on the Oregon Medical Association’s Quality Care Committee and the Oregon Health Care Quality Corporation’s Measurement & Reporting Committee. Ms. Reuland serves on the Oregon Medical Association’s Education Committee.

Summary Briefs Developed by OPIP Leadership:
In order to respond and inform a number of efforts in the state, OPIP developed a number of briefs/materials that were disseminated through one-on-communication and strategic meetings.

1. Improving the CCO Incentive Metrics: OPIP Experience with Addressing and Improving Care – April 2013. As part of the response to the rapidly emerging CCOs, OPIP Leadership created a summary brief of OPIP’s experience with each of the incentive metrics that were relevant to pediatric practices. This outline is designed to help CCO leadership understand the complexity of engaging primary care providers in order to truly and meaningfully move a quality metric. This brief was disseminated to selected stakeholders in CCOs.

2. Leveraging Synergy in Efforts at the State, CCO, and Practice Level Focused on Patient Experience of Care Surveys – April 2013. OPIP met with leadership within Oregon Health Authority involved with various efforts at the CCO and practice-level focused on patient experience of care surveys. OPIP developed a strategic summary or preliminary lessons learned based on their experiences in working with practices on implementing and using patient experience of care surveys and potential implications for the CCO level work.
3. **Next Steps for the Patient Centered Primary Care Institute (PCPCI) – Memo from OPIP about Important Next Steps July 2013.** OPIP developed a strategic memo for leadership of the Quality Corporation about our perceptions of priority areas for the PCPCI in the upcoming year based on learnings about involvement in the PCPCI in the last year.

**Summary Briefs by the Broader OPIP Partners Committee:**

The OPIP Partners Committee is intentionally comprised of public and private entities with a shared investment in child health care quality, and the shared goal of improving the health of the children and youth of Oregon. This engaged group meets quarterly and on an ad hoc basis, during which highlights of key Oregon health reform activities are summarized.

The Office of Health Policy and Research revised the PCPCH standards. In order to provide feedback that incorporated the voice of the practices and these Partner Committee stakeholders OPIP administered a survey to the practices and OPIP partners to obtain their feedback, held two group-level conference calls, and facilitated an in-person meeting with the OPIP partners to review comments and suggestions.

Based this information gathered, OPIP distilled the collaborative feedback provided and created a 26-page public comment that was submitted, titled, “June 2013: Oregon Health Authority’s Patient-Centered Primary Care Home (PCPCH) Standards Update: Comment Based on Front-Line Experience, Partner and Practice-Level Review”. The comments submitted provided specific feedback, as well as solutions, for potential improvements to the wording and intent of the measures.

**Meetings with Coordinated Care Organizations (CCOs):**

A key lever for health reform in Oregon is the development and implementation of Coordinated Care Organizations. OPIP & the OPIP Partners are committed to ensuring that the evolving Coordinated Care Organizations ensure a maternal and child health focus.

To help inform their efforts and how this can be accomplished, OPIP has facilitated or attended a number of meetings:

1. **March 2013 Meeting of the OPIP Partners, FamilyCare, and Health Share:** OPIP facilitated a meeting with key leaders in FamilyCare and Health Share and the OPIP Partners. The goal of the meeting was to hear from these two CCOs about their efforts to ensure a maternal and child health focus and then to provide them with specific, concrete feedback about how their efforts could be enhanced. Prior to the meeting, the CCOs were sent the policy brief created in early 2012 titled “Ensuring a Maternal and Child Health Focus in the Coordinated Care Organizations” that had been distributed to leadership in the Oregon Health Authority. OPIP also created a series of slides that highlighted OPIP and the OPIP Partners’ work on areas that are specifically highlighted in the CCO Incentive metrics.

2. **Individual meetings with individual CCOs:** OPIP has met with a number of staff from various CCOs to provide them with input and guidance that is based on recent experiences with practices and in facilitating the ABCD Learning Collaborative. A number of these meetings focused on how the CCO could leverage and enhance their efforts around developmental screening and care coordination. Additionally, OPIP participated in a number of meetings with Health Share and FamilyCare focused on how care could be better integrated with school nurses and school based health centers.
Public Comments:

The OPIP Executive Leadership also submitted public comments to the following calls for public input:

- Oregon Population Health Profile – August, 2012
- HEDIS 2014 Revisions: Inappropriate Cervical Cancer Screening in Adolescent Females, Childhood Immunization Status – March 2013
- U.S. Preventive Services Task Force, Prevention of Dental Caries in Children From Birth Through Age 5 Years – June 2013

OPIP Publications


OPIP Meetings and Presentations

Meetings Attended and Presented:

1. National Improvement Partnership Network Meeting – September 2012
   Dr. Gillespie, Mr. Ross, and Ms. Reuland attended the meeting. Ms Reuland led presentations on “Visual Data Display: How do IP’s Most Effectively Share Data to Inform and Engage QI Teams” & “Innovative Project Designs”.

2. Alaska CHIRPA Stakeholder Meeting and Collaborative on Care Coordination – November 2012
   Ms. Reuland attended and presented on the Alaska Medical Home Office Report Tool findings, the T-CHIC Medical Home Priorities and Innovative Strategies that may be considered by the Alaska sites.

3. Pediatric Measures – Center of Excellence (PM-CoE) Expert Work Group Meeting – February 2013
   Ms. Reuland attended as a member of the Expert Work Group.

   Ms. Reuland attended the final meeting of the the ABCD III grantees and presented highlights from the ABCD III project and key learnings.

5. Strengthening Primary Care and Care Coordination for Healthy Child Development: Lessons from ABCD – February 2013
   Ms. Reuland attended and participated in facilitated discussions and reports out.

   Ms. Reuland and Mr. Ross facilitated or presented on over half of the presentations at this meeting.

   Ms. Reuland presented on OPIP. Dr. Gillespie and Mr. Ross participated in facilitated conversations.
**Regional and National Presentations/Posters:**


OPIP Organizational Development

Institutional Home:

OPIP continues to be housed within Oregon Health & Science University in the Department of Pediatrics. We are thankful for the continued support of OHSU for the translational and improvement work that we do. **OPIP’s Steering Committee** (see next page) meets monthly, is comprised public and private stakeholders, and provides oversight and guidance to the OPIP staff, as well as input into project level work.

Funding:

OPIP’s funding is from the following sources:

- Contracts from the Oregon Health Authority, Division of Medical Assistance Programs, and the Commonwealth Fund for the ABCD III Learning Collaborative.
- Contract from the Oregon Health Authority, Office of Health Policy and Research for the Consulting Activities Related to T-CHIC.
- Contract from the Oregon Health Authority, Office of Health Policy and Research for the Enhancing Children Health in Oregon Learning Collaborative
- Contract from the Quality Corporation for the Patient Centered Primary Care Institute.
- Operational funding from the Department of Pediatrics at Oregon Health & Science University.

Staffing:

Appendix C provides an overview of the OPIP organizational chart.

We have hired one new staff member this year, and are excited about what he brings to the team. **Neil Braun, MPP, RPh** joined the Oregon Pediatric Improvement Partnership as a Research Associate for Quality & Systems Improvement in August 2013. From 2008 to 2013, Mr. Braun worked as a Project Manager within the Public Health Department of the Vancouver Coastal Health Authority, in Vancouver, Canada. Within that role, he facilitated various public health service providers and policymakers within and outside the organization to complete a diversity of quality improvement projects related to preventative public health services. In his role with OPIP, Mr. Braun is responsible for coordinating data collection and analyses across OPIP’s projects, assisting in the development of evaluation metrics for projects, and disseminating the evaluation findings and analyses from projects.

OPIP Website and QI-Teamspace:

**OPIP Website (www.oregon-pip.org)**

OPIP continues to strive to post relevant project summaries and tools and resources developed.

**OPIP QI Teamspace (projects.oregon-pip.org)**

This is our online community for quality improvement. The site allows us share spaces online for the various projects and practices that we facilitate. We are currently using the site for our ECHO, TCHIC, and PCPCI projects. We plan to maintain this resource for the practices after the projects are over to help them maintain connections.
Collaborations

**OPIP Steering Committee & OPIP Partners Committee:**

In August 2012 OPIP conducted a strategic survey what was then called the OPIP Executive Committee. The purpose of the survey was to better understand amongst the partners how the collaboration could be enhanced, and to receive organization feedback and input. Based on the findings from the survey and the needs identified by the OPIP Leadership, *two* separate committees (OPIP Steering Committee & OPIP Partners committee) were formed to ensure the needs of the OPIP staff and the organizations that OPIP partners with were better met. A list of the members of each committee can be found on the OPIP website ([www.oregon-pip.org](http://www.oregon-pip.org)).

**OPIP Steering Committee:**

The OPIP Steering Committee meets monthly, and is charged with providing oversight and guidance to the OPIP staff, as well as input into project level work. The main purposes of the Steering Committee are:

- **OPIP Operations:** Reviews and provides guidance to ensure the sound and successful operation, development and management of OPIP. No fiduciary responsibility or review.
- **OPIP Projects:** Provides routine input into the design and implementation of OPIP projects and initiatives.
- **Technical and Content Expertise:** Oversees the appointment of subcommittees to address specific issues and advises on appointment of individuals serving on project specific task forces to ensure appropriate content and technical expertise are represented.
- **OPIP Representation:** Represent the OPIP and the OPIP mission where appropriate.

We are extremely thankful for the wisdom and guidance provided by this committee to ensure that our work is meaningful and sustainable.

**OPIP Partners Committee:**

The OPIP Partners Committee meets quarterly and is specifically designed to allow for collaboration across the partners by highlighting quality improvement and measurement efforts of the partners. The functions of the OPIP Partners Committee are:

- **Sharing of successful initiatives and disseminating best practices:** The partners will share with each the other the work they are doing to improve the health of children and youth and the key learnings that are applicable to the other members.
- **Identify areas of Synergy:** Partners will identify areas of synergy across their efforts and/or where there should be synergy in efforts to ensure a meaningful impact on the health of children and youth in Oregon.
- **Build collaboration and consensus:** Through shared discussions, the partners will help to identify areas of collaboration and consensus about opportunities to improve the health of children and youth in Oregon.
- **Serve as a resource for policymakers in providing guidance and input:** The partners meetings will represent an opportunity for policymakers to share and discuss key policy efforts and gain input and insight from the collective group of stakeholders.
The following meetings of the OPIP Partners were held with focus on the following topics:

- **February 2013**: Conference call to Discuss the Proposed PCPCH Revisions & to Receive Input and Feedback.
- **March 2013**: Meeting with Health Share and FamilyCare (two Portland-based CCOs) focused on how they can ensure a maternal and child health focus in their efforts.
- **June 2013**: Methods and strategies to Identify Children and Youth with Special Health Care Needs. Spotlight of efforts within Children Health Foundation and the Enhancing Child Health in Oregon Learning Collaborative and facilitated discussion about the key learnings and implications.

Lastly, when needed, subgroups of these committees will meet to review current health reform efforts and to synthesize summary briefs to help inform policymakers. The purpose of this subgroup will be to address issues that arise for which a unified voice to inform policy level efforts, as warranted.

### American Academy of Pediatrics:

Dr. Gillespie serves as a member of the AAP’s Medical Home for Children Exposed to Violence Project Advisory Committee (PAC). The purpose of this PAC is to increase awareness of the impact of exposure to violence on the health and well-being of children, and to create educational opportunities and materials for practicing providers. Through the course of this committee’s work, the AAP has created a website of resources and information, a series of educational webinars, and a case study-based toolkit for incorporating screening and surveillance for violence exposure into primary care practices.

Ms. Reuland serves on an expert work group for the Pediatric Measures Centers of Excellence, which is co-housed at the American Academy of Pediatrics.

### National Improvement Partnership Network:

OPIP is a formal partner of the National Improvement Partnership Network (NIPN). NIPN provides OPIP with an essential group of national partners to learn from and share ideas about innovate improvement and measurement strategies. OPIP staff participates in monthly NIPN calls in which strategies, tools, and information is shared. OPIP has presented on three of these calls. Dr. Gillespie continues to serve on the National Improvement Partnership Network’s Leadership Team as well as the Strategic Planning Team. NIPN continues to expand its membership with new state IPs integrating into the network through the Category E work of the CHIPRA Demonstration Grants. The Strategic Planning Team met in Phoenix, AZ in March to begin to develop specific goals and strategies for the ongoing development and sustainability of NIPN.

**These goals include:**

- By 2015, NIPN will have developed and implemented a sustainable business model and decreased dependence on grant funding.
- Assure a sustainable QI infrastructure for children’s health care in every state.
- NIPN will become an improvement science and data driven organization.
- Demonstrate value to key national stakeholders by providing solutions to common pediatric health problems.

OPIP Executive Leadership and senior staff also participate in the NIPN Annual Meetings and Operations Meetings for NIPN, which provide a valuable source of mentorship and ongoing support for project design and implementation.
Goals for the Upcoming Year

The ECHO, T-CHIC and PCPCI projects continue in the next annual report period. OPIP will strive to meet the goals and objectives of these projects in a meaningful way. We also will continue to strive to be a resource and partner in informing the significant health and early learning system reform efforts.

Below are strategic goals identified by the OPIP leadership to address in the next annual report period:

- **Dissemination of Project Level Findings**
  - Efforts will be devoted to distill the key findings across the projects and create summary materials that can be distributed on the OPIP website.
  - Additionally, OPIP will strive to present the findings at a regional or national meeting.

- **Seek Funding for New Projects**
  - OPIP senior staff will be seeking funding to support two additional projects. OPIP is exploring projects that address three out of four of the strategies noted in the OPIP mission.

- **Engagement of Additional Practices**
  - As OPIP seeks additional funding, we will be striving to work with additional practices across the state. This will include targeted efforts to pediatric and family medicine practices. We also eager to do work with School Based Health Centers.

- **Enhanced Engagement of Patients**
  - As was noted in this report, OPIP has invested significant work and resources around or mission strategy to “ensure the patient is at the center of measurement and improvement activities” through hiring a parent to advise our projects, ensuring parents are the key note speakers for all in-person learning sessions, and facilitation with practices in partnering with their patients.
  - That said, we look forward to identifying and implementing additional methods by which patients are engaged and partnered with at every level of our projects and practice-level work.

- **American Board of Pediatrics (ABP) Maintenance of Certification (MOC)**
  - OPIP will be submitting an application to be a “Portfolio” provider for MOC efforts and will be submitting MOC credit for three quality improvement projects.

- **Expand Membership of the Oregon Pediatric Improvement Partnership Partners Committee**
  - OPIP is eager to expand the Partners Committee. We will be focusing these first efforts on identifying and inviting person with perspective from the following:
    - Family medicine – Front-line family medicine providers
    - Federally Qualified Health Centers
    - Private purchasers
    - Parents and adolescents/youth, and/or consumer advocacy
    - School based health centers
    - Others who focus on quality improvement (including in-patient services)
Appendix A

Glossary/ Acronym List

- **211**: A parent 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.
- **ACA**: Affordable Care Act - A federal statute signed into law in March 2010 as a part of the healthcare reform agenda of the Obama administration. Signed under the title of The Patient Protection and Affordable Care Act, the law included multiple provisions that would take effect over a matter of years, including the expansion of Medicaid eligibility, the establishment of health insurance exchanges and prohibiting health insurers from denying coverage due to pre-existing conditions. ACA also refers to a set of specific conditions identified by the Oregon Legislation in which practices will get enhanced reimbursement.
- **ACO**: Accountable Care Organizations are a type of payment and delivery reform model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.
- **ASO**: Autism Society of Oregon.
- **Attribute vs. Standard (PCPCH)**: The Core Attributes and Standards are intended to establish a common framework for understand 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 – IHI model for quality improvement learning collaborative.
- **CAHMI**: Child and Adolescent Health Measurement Initiative - is 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.
- **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.
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- **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;
  - Build and use effective communication strategies among family, the medical home, schools, specialists, and community professionals and community connections; and
  - Help improve, measure, monitor and sustain quality outcomes (clinical, functional, satisfaction and cost)

- **CCO** - Coordinated Care Organizations – is a network of all types of health care providers who have agreed to work together in their local communities for people who receive health care coverage under the Oregon Health Plan (Medicaid).

- **CCN** – Community Connection Network – is a resource for children and youth with complex health needs. CCN uses a multidisciplinary team approach to care coordination – it provides a forum for local health, social,, and educational services to come together.

- **CDRC** – Child Development and Rehabilitation Center serves as an education and research center for health professionals, provides interdisciplinary clinical services for persons with developmental disabilities and other special health care needs, serves as the state's Title V Agency for children with special health needs, and supports the philosophy of partnership with families, health care providers and the community.

- **CHIPRA** – Children’s Health Insurance Reauthorization Act works to implement selected provisions of the legislation related to children's health care quality.

- **CMS** – Centers for Medicare and Medicaid Services is a US federal agency which administers Medicare, Medicaid, and the Children’s Health Insurance Program.

- **Core Measures** - This refers to the initial core set of quality measures coming out of the CHIPRA legislation, for children enrolled in Medicaid and the Children’s Health Insurance Program (CHIP). The Centers for Medicare and Medicaid (CMS) proposed the measures, and are asking States to report on the CHIPRA core set.

- **CPT** – Current Procedural Terminology - the most widely accepted medical nomenclature used to report medical procedures and services under public and private health insurance programs.

- **DMAP** – Department of Medical Assistance Programs is the agency that administers Medicaid and the State Children’s Health Insurance Program (CHIP) in Oregon.

- **ECHO** - Enhancing Child Health in Oregon - a learning collaborative with 8 practices workings to apply the principles and processes of Medical Home.
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- **EI**- Early Intervention - Individually designed services for children birth to three and support for parents to enhance children’s physical, cognitive, communication, social or emotional and/or adaptive development

- **ENCC** – Exceptional Needs Care Coordinators - a type of specialized case manager at Medicaid managed care plans.

- **F2F** – Family to Family Health Information Center - provides information to families who are navigating the complex world of special health care needs

- **Help Me Grow** – Is a project in Oregon that is working to expand 211 and START (Screening Tools and Referral Training- a training program around implementation of developmental screening)

- **IDD** – Institute on Development and Disability at OHSU works with patients, families, clinicians, researchers and many other professionals to meet the goals of improving the lives of people with disabilities

- **IHI** – Institute for Healthcare Improvement focuses on motivating and building the will for change; identifying and testing new models of care in partnership with both patients and health care professionals; and ensuring the broadest possible adoption of best practices and effective innovations.

- **LS** – Learning Session - Face to face meetings of the learning collaborative, including group interaction and expert speakers. There will be five over the course of the ECHO project.

- **MCO** – Managed Care Organization - a health insurance plan that covers the services of a particular network of doctors and other providers for people enrolled in the plan.

- **MOC** – Maintenance of Certification - The process of keeping physician certification up-to-date through one of the 24 approved medical specialty boards of the American Board of Medical Specialties

- **MOSOPS**- Medical Office Survey on Patient Safety – is a survey that is designed specifically for outpatient medical office providers and staff and asks for their opinions about the culture of patient safety and health care quality in their medical offices

- **MHI-RSF** – Medical Home Index: Revised Short Form – is a validated self-assessment and classification tool designed to translate the broad indicators defining medical home into observable, tangible behaviors and processes of care within any office setting.

- **MHORT**- Medical Home Office Report Tool – The measurement tool of the TCHIC demonstration grant which includes five modules – Module 1: the Demographic Form, Module 2: Practice Characteristics, Module 3: MHI-RSF, Module 4: NCQA PCMH 2011 and Module 5: State Specific Items
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- **NAMI** – National Alliance on Mental Illness - the nation’s largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, supports and research and is steadfast in its commitment to raise awareness and build a community for hope for all of those in need.

- **NE** – National Evaluator – Organization charged with conducting a rigorous evaluation to determine the impact of grantee activities on the quality of children’s health care

- **NCQA** – National Committee for Quality Assurance is a non-profit organization dedicated to improving health care quality

- **NCQA PCMH** - National Committee for Quality Assurance Patient Centered Medical Home – is a set of standards used to systematically evaluate and recognize clinician practices functioning as medical homes.

- **OBSTERM** – A short term for Observation term in an EMR. An OBSTER is a data point values (such as weight, height, etc) that is saved to the database under obsterms specific to each data point. It is a database heading or field that holds the observation values from each encounter.

- **OCCAP** – Oregon Council of Adolescent and Child Psychiatry

- **OCCYSHN** – Oregon Center for Children and Youth with Special Health Needs promotes optimal health, development and well-being of Oregon’s children and youth with special health needs

- **OFSN** – Oregon Family Support Network - Oregon families supporting Oregon families with children and adolescents with emotional, behavioral, mental and/or physical challenges and special needs.

- **OHA** – Oregon Health Authority is the organization at the forefront of lowering and containing costs, improving quality and increasing access to health care in order to improve the lifelong health of Oregonians.

- **OPAL-K** – Oregon’s Psychiatric Access Line about Kids is a partnership of the Oregon Pediatric Society, Oregon Health and Sciences University, Oregon Council of Child and Adolescent Psychiatry and the Oregon Family Support Network that provides primary care physicians timely phone access to child psychiatric consultation for children and adolescents birth to age 18.

- **OPIP** – Oregon Pediatric Improvement Partnership is an improvement partnership between OHSU, Medicaid, Office of Family Health, Oregon Pediatric Society, Children’s Health Foundation, Child and Adolescents Health Measurement Initiative (CAHMI) and Oregon Center for Children and Youth with Special Health Care Needs

- **OPS** – Oregon Pediatric Society is a non-profit, child health organization made up of 500+ Pediatricians across the state who are leaders in their communities and volunteer hundreds of hours to make great change.
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- **PCMH** – Patient Centered Medical Home is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

- **PCPCH** – Patient Centered Primary Care Home is a model of primary care that has received attention in Oregon and across the country for its potential to advance the “triple aim” goals of health reform: healthy population, extraordinary patient care for everyone and reasonable costs, shared by all.

- **PCPCI** – Patient Centered Primary Care Institute. The Institute connects practices in all stages of patient-centered primary care home transformation—from those looking to begin the process to those already recognized as primary care homes—to a broad array of technical assistance. Through this assistance the Institute helps practices meet the requirements for the Oregon Health Authority’s Patient-Centered Primary Care Home recognition. The Institute also helps practices move beyond the checklist and realize the Triple Aim outcomes of a healthy population, extraordinary patient care and reasonable costs.

- **PERC** – Practice Enhancement Research Coordinators/Practice Facilitator. Provide coaching and support to practices.

- **PDSA** – Plan, Do, Study, Act is a useful tool for documenting a small test of change.

- **PMPM** – Per member/Per Month – a capitation payment method where an insurance company pays an amount to a primary care physician based on the number of members on the physician's panel.

- **PSC** – Pediatric Symptom Checklist.

- **Q-Corp**– Oregon Health Care Quality Corporation - is an independent, nonprofit organization dedicated to improving the quality and affordability of health care in Oregon by leading community collaborations and producing unbiased information.

- **Teamness** - unique set of characteristics including technical or functional expertise, problem-solving and decision making and interpersonal skills.

- **Tier** - This is referring to the tier system in the PCPCH standards identifying the level of medical home a practice is, and the level of accompanying enhanced reimbursement. Tier 1 measures focus on foundational PCPCH elements that should be achievable by most practices in Oregon with significant effort, but without significant financial outlay. Tier 2 and Tier 3 measures reflect intermediate and advance functions.

- **Triple Aim** - The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. It is IHI’s belief...
Appendix A

that new designs must be developed to simultaneously pursue three dimensions, which we call the “Triple Aim”: Improving the patient experience of care (including quality and satisfaction); Improving the health of populations; and reducing the per capita cost of health care.
Appendix B - Facilitation Overview

Practice facilitation is a cornerstone of the support OPIP provides to the practices we work with. Having an understanding of the services we provide as facilitators (and the mutual expectations involved) establishes a necessary foundation for our work. What follows is a description of this process, and the roles and expectations of both the facilitator and the participant.

How We Work
The objective of facilitation is to transfer skills, tools and knowledge to practices in order to implement and sustain improvement. By working toward this end, we hope to maximize the efficacy of the current project (in this case PCPCI)- but also that of the improvement journey once our initial engagement period concludes.

We use a coaching model for this work, which is a specific process of interaction over a period of time that encourages a shift in what practices do, and how they do it. This respectful, non-judgmental, and inquiring form of conversation and listening expands the ability to make significant and sustainable improvements. Through our training and expertise, we can help to:

- Hold productive & effective meetings
- Develop action plans to meet improvement goals
- Engage patients and families in your improvement efforts
- Improve team concepts and collaboration skills
- Understand and address barriers to improvement
- Connect with and learn from practices that have valuable experience

Expectations for OPIP Facilitator

- Commit to an open, honest, collaborative coaching relationship
- Listen carefully to what practice teams say and ask constructive questions
- Respect the confidentiality of facilitator and practice
- Maintain materials and resources for the Learning Collaborative on the QI Teamspace (online shared community)
- Serve as a coach for quality improvement approaches to practice change
- Be a resource for you to use in accomplishing your goals; connect you with technical assistance and other practices with relevant experience

Expectations for Practices

- Commit to an open, honest, collaborative coaching relationship
- Identify and cultivate your practice’s improvement team (meet regularly! At least once per month outside of our facilitation calls/site visits), ideally including:
  - Provider Champion
  - Nurse or Medical Assistant
  - Office Manager
  - IT/EMR Staff as necessary
  - Parent Partner
- Participate in monthly facilitation calls
- Participate in periodic in-person meetings with OPIP staff (site visits)
- Complete required data collection and reporting
- Attend Learning Sessions
- Attend the two mid action period webinars
- Record and track team’s progress using the project planning tool

Contact Dave Ross (rossda@ohsu.edu) with questions