

# AHRQ Infrastructure for Maintaining Primary Care Transformation (IMPACT) Grants

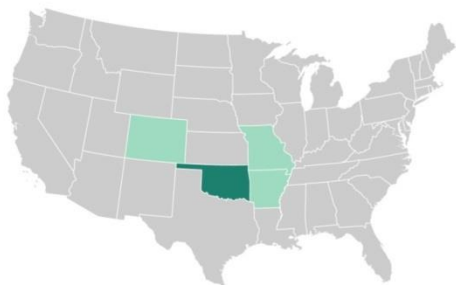
## Primary Care Extension in Oklahoma: An Evidence-Based Approach to Dissemination and Implementation of Innovations

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### Overview of Primary Care Extension in Oklahoma



**Model State:** Oklahoma

**Partner States:** Arkansas, Missouri, Colorado

AHRQ's IMPACT grants were designed to support State-level primary care improvement efforts using extension agents (i.e., practice coaches)—and to learn how these programs could serve as models for other States.

Oklahoma's Primary Care Extension Service model engaged existing county-based organizations and provided them with new resources to build an infrastructure for health improvement organizations in each of its 77 counties.

The story of this program's success lies in the power of working at the community level and developing relationships to sustain local community health

organizations. In Oklahoma, primary care extension is grounded in a history of primary care practice improvement through the Oklahoma Physicians Resource Research Network, with its established relationships with primary care practices and tested model of practice improvement. In this largely rural State, a familiarity with the agricultural Cooperative Extension model translated to a methodology for spreading innovations in primary health care improvement through the development of County Health Improvement Organizations (CHIOs).

### Infrastructure Elements

*"There is a huge cultural gap that exists between public health and primary care. I can't say we have made a completely pleasant marriage in all counties. They still don't fully understand the concept of working together, but we've certainly made a lot of progress."*

—Jim Mold, MD, MPH, Principal Investigator

CHIOs were the main operational element of Oklahoma's primary care improvement infrastructure. The use of CHIOs to assist with primary care transformation efforts was promoted at a statewide conference, and the creation of a certification process helped dispel concerns about duplication of services from existing community agencies and organizations. Any organization that provided primary care could apply for certification as a CHIO. Requirements included: nonprofit status; inclusion of primary care, hospital, public and mental health, and other stakeholders on the board of directors; a primary care advisory committee; and endorsement of the County Health Improvement Plan (CHIP).

Primary Care Extension in Oklahoma provided crucial support to the counties in the certification process. By mandating a communitywide board of directors that embraced a common goal, CHIP enhanced communication between various sectors of care to build a broader infrastructure. Startup grants offered incentives for quality improvement work in the practices.



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## Program Impacts

As the CHIOs became certified, they were able to join the Oklahoma Primary Healthcare Extension System, which provided resources, services, and coordination between participating groups. Academic medical centers were an important partner in this effort, and provided a pathway for translating and disseminating findings. For example, the Oklahoma Clinical and Translational Science Institute at the University of Oklahoma, comprised of representatives from academic institutions as well as State and county health agencies, developed a resource center and an improvement cooperative to further support dissemination efforts.

County-based efforts catalyzed group quality improvement among local physicians and brought diverse funding for more comprehensive care. For instance, when Washington County in northeast Oklahoma completed its CHIP, it discovered that the county had a suicide rate of twice the national average and higher than any other county in Oklahoma. Primary Care Extension in Oklahoma helped practices construct a quality improvement process and brought in experts on depression management in primary care, resulting in implementation of depression screening programs at almost all clinical practices in the county. Subsequently, the county has received funding to test the effectiveness of social work in primary care and to provide care coordination for patients with depression. An effort is also underway to supply a telepsychiatry link from the University of Oklahoma.

County-based efforts were more successful when they helped to focus assistance on locally identified problems, addressing practice transformation from the perspective of the practitioner, rather than imposing a larger improvement agenda from the outside.

## Dissemination Efforts to Partner States

- **Colorado:** Colorado had a powerful quality improvement network that already existed, with strong organization and experienced support personnel, particularly in the Denver area. The State also has a strong commitment to establishing an extension center, and key stakeholder organizations meet regularly to engage all of the major players in primary care, health policy, and practice transformation efforts in the State. Colorado plans to build on its practice facilitation resources and deploy them through a network of collaborating organizations. It would like to adopt the CHIO model, and is currently working to find the appropriate geographical units for organizing the regions. (It may choose to use Medicaid districts, since some of its counties are sparsely populated.) An appropriate division of roles among key stakeholders also needs to be determined. Colorado used its work with the Oklahoma and New Mexico primary care transformation extension projects to lay the groundwork for pursuing funding through several sources and is building the extension center concept into its State Innovation Model grant application.

*"If I had approached those practices individually and asked, 'Wouldn't you like to do some quality improvement in your practice?' or 'Wouldn't you like to transform your practice?,' they would have hung up the phone on me. But because it was a countywide project, addressing a real need that the county had identified, and they wanted to be part of something bigger than themselves, they all joined the project. That is a major benefit of forming the CHIOs and doing the project the way we did."*

—Jim Mold

- **Arkansas:** Arkansas currently has two quality improvement initiatives active at the State level that are stimulating the development of patient-centered medical homes (PCMHs) in primary care—the Comprehensive Primary Care Initiative, sponsored by the Centers for Medicare & Medicaid Services, and the statewide PCMH initiative. The University of Arkansas Medical School regional centers, part of the Area Health Education Center system, are also spreading the transformation work, beginning with their many primary care residency programs and then reaching out to other practices. They



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developed a toolkit for PCMH implementation and piloted it with three practices outside of the University of Arkansas system, spreading the use of best practices such as disease registries, care coordination, information technology support, and chronic disease workflows. The CHIO model is also of interest to stakeholders in Arkansas, but has not yet been implemented. Arkansas has a strong quality improvement environment in terms of reimbursement incentives, support mechanisms, and tools in place, and will therefore be ready to implement a primary care extension service once funding becomes available.

- **Missouri:** The IMPaCT mission in Missouri was complicated by fragmentation in the State's quality improvement initiatives. There were several active stakeholders, such as the Area Health Education Centers in St. Louis, Columbia, and elsewhere, as well as a statewide PCMH initiative. So far, however, there has been little communication and coordination between these efforts. The Missouri team made an early decision to focus the IMPaCT project efforts on Pettis County, where there was an established relationship with the University of Missouri, Columbia. The team was able to connect practice managers to community resources, so that each practice now has a resource guide, and help advance conversations about PCMH and population health management. There is more communication among local hospitals, Community Health Centers, and public health entities in Missouri, and the University has joined with several rural hospitals in a collaborative effort to improve care and support smaller health systems. Although the hospital and Community Health Centers are using electronic health records, they are not yet able to provide adequate data for population health management, and only one private primary care practice had one in place. At the State level, the legislature approved funding for a telemedicine project (Project ECHO) to provide consultation to remote practices. These efforts aim to break down the existing silos that prevent communication and collaboration on quality improvement between groups.

### Challenges and Sustainability

The Oklahoma Primary Care Extension Service model was designed with sustainability in mind, relying on two assumptions: care improvement efforts should be community-based and financially supported by funds from health insurance companies as well as State and Federal Government sources. To achieve this, the model used county-based health centers with community care networks modeled after the successful regional experience in North Carolina, and relied on the strength of prior organization of community coalitions at the county level in Oklahoma, particularly the Turning Point Partnerships. The extension service included support to improve care coordination in the community, as well as other improvement efforts that would attract the support of insurers.

CHIOs in Oklahoma received sustaining funding thanks to the efforts of an active legislator who was able to appropriate funding to continue the program after the IMPaCT grant ended.

### Lessons Learned and Implications for Others

- **Relationships are key for effective spread of the extension center model.** Building strong relationships was key for building acceptance of the model at the State level and for the adoption of change among individual practices. It helped practices be willing to try something new and stick with it if they had a trusting relationship with someone who had already experienced practice transformation and could support them through the process.
- **Relationships also help build bridges among disconnected health care delivery organizations and connect them with State and local entities.** Fragmentation of health care delivery engendered by a history of separate institutions not interacting or communicating with each other had resulted in some parallel systems with resulting inefficiencies. These silos are slowly being bridged by building relationships between the people in these organizations.



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- **Focus first on making practice changes that are meaningful to providers.** Practitioners often have difficulty embracing the idea of practice transformation in the abstract, but they usually recognize that there are things they could improve in their practice. To gain buy-in from practitioners for practice transformation, it can help to focus first on improving an aspect of care that they think is important; after that, the practice transformation and PCMH concepts fall into place. For example, the small projects funded in Oklahoma focused on depression, diabetes, opioid management, care transitions, and childhood obesity. While none focused specifically on becoming a PCMH, all of them addressed the concepts inherent in primary care transformation.
- **Programs that are adaptable will spread more easily.** Stakeholders in partner States borrowed what they liked from the model developed in Oklahoma, but adapted it to the conditions in their own States. Although some of the same resources and organizations were available across the States (for example, county-level coalitions and partnerships) and some of the same problems existed (for example, public health organizations that were not well connected to primary care clinicians or hospitals), the States needed to adapt the Oklahoma extension model to meet the needs of local conditions.
- **Academic partners help translate and disseminate findings.** Academic medical centers, through the Oklahoma Primary Care Extension System, assisted the CHIOs with population health management, getting the results of research into practice, and communicating the lessons derived from practical implementation to researchers. The interface between practice and academia was essential to ensure that cutting-edge innovation received input from both directions.

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### For More Information:

Mold JW. A cooperative extension service for primary care in Oklahoma. J Okla State Med Assoc 2011;104(11-12):414-8.



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