

Idaho's PCMH Mentorship Framework

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Introduction

A Patient Centered Medical Home (PCMH) mentorship framework is important in creating a strong network of knowledgeable and experienced primary care clinics across the State of Idaho. The framework will act as a structure to help spread best practices; to support all the Statewide Healthcare Innovation Plan (SHIP) cohort clinics in their transformation efforts; and to create additional opportunities through building clinic-to-clinic relationships.

Idaho has numerous primary care clinics who have achieved national PCMH accreditation. Many have done so from previous efforts, such as the Safety Net Initiative and the Idaho Medical Home Collaborative (IMHC) Pilot. The purpose of this framework is to assist in the development of a peer-to-peer support system to support SHIP cohort clinics in system change, PCMH transformation, data quality, and additional tasks related to their SHIP participation and the larger efforts involved in healthcare reform.

This framework reflects the state's recognition of the important role that mentoring plays in the PCMH transformation experience. The rationale is to promote effective mentoring by describing the key concepts, roles, and needs, along with practical strategies for nurturing rewarding relationships and recommendations for maintaining healthy relationship building amongst primary care clinics statewide and beyond SHIP.

The components outlined in this framework derive from the convening of the Idaho PCMH Mentorship Subcommittee during May 2017. Subcommittee members included members of IMHC Workgroup, Regional Collaborative Chairs and Co-Chairs, Public Health District staff, Department of Health and Welfare staff and contractors, participating SHIP clinic Physician Champions, Boise State University and University of Idaho faculty members, a Veterans Administration (VA) Office of Academic Affiliations Physician Consultant, as well Health Plan/ Payer staff from multiple entities. The University of Nebraska – Lincoln Graduate Mentoring Guideⁱ was utilized as a base in which this framework was developed. Additional mentoring definitions were provided by the VA Office of Academic Affiliations, Centers of Excellence in Primary Care Education and the National Parkinson Foundation (NPF) Mentoring Programⁱⁱ.

Background

In December 2014, the Idaho Department of Health and Welfare (IDHW) received a State Innovation Model (SIM) grant from the Center for Medicare and Medicaid Innovation (CMMI). The grant funds a four-year Model Test that began on Feb. 1, 2015 to implement Idaho's SHIP. During the grant period, Idaho will demonstrate that the state's healthcare system can be transformed through effective care coordination between primary care providers practicing patient-centered care and broader Medical-Health Neighborhoods comprised of specialists, hospitals, behavioral health professionals, long-term care providers, and other ancillary care services. Idaho's SHIP model provides supports at every level for clinics as they transform to the PCMH model. The State

of Idaho is comprised of seven Public Health Districts (PHDs), as shown on Figure 1, which provide resources and technical assistance to clinics throughout the transformation. Seven Regional Collaboratives (RCs) support clinics by working to improve the coordination of care within the Medical-Health Neighborhood and identifying and sharing best practices for successful care coordination.

Idaho’s SHIP seeks to transform primary care practices across the state into PCMHs. Idaho is establishing PCMHs as the foundation of the state’s healthcare system by making them the vehicle for delivery of primary care services. The PCMH model focuses on preventive care, keeping patients healthy and stabilizing patients with chronic conditions. A portion of SHIP grant funding is being used to provide training, technical assistance and coaching to assist practices in this transformation.

PCMH mentorship between practices was an important component of the original Idaho SIM Test Proposal. The proposal described how, based on their experience as leaders in patient-centered primary care, some practices in Idaho are well positioned to be a valuable resource to other practices in their efforts to build capacity around the components of the PCMH model. It was determined that the Idaho Healthcare Coalition (IHC) and the RCs will seek to leverage this expertise where possible by encouraging practice mentor opportunities to help practices learn from each other’s lessons and prior experience. As part of a road map for health system transformation, the proposal outlined milestones relating to PCMH mentorship. It was proposed that in the first year of SHIP, a PCMH mentoring program would commence to assist practices through the transformation process. In the second year, the program would continue mentoring less experienced PCMHs by more experienced PCMHs.

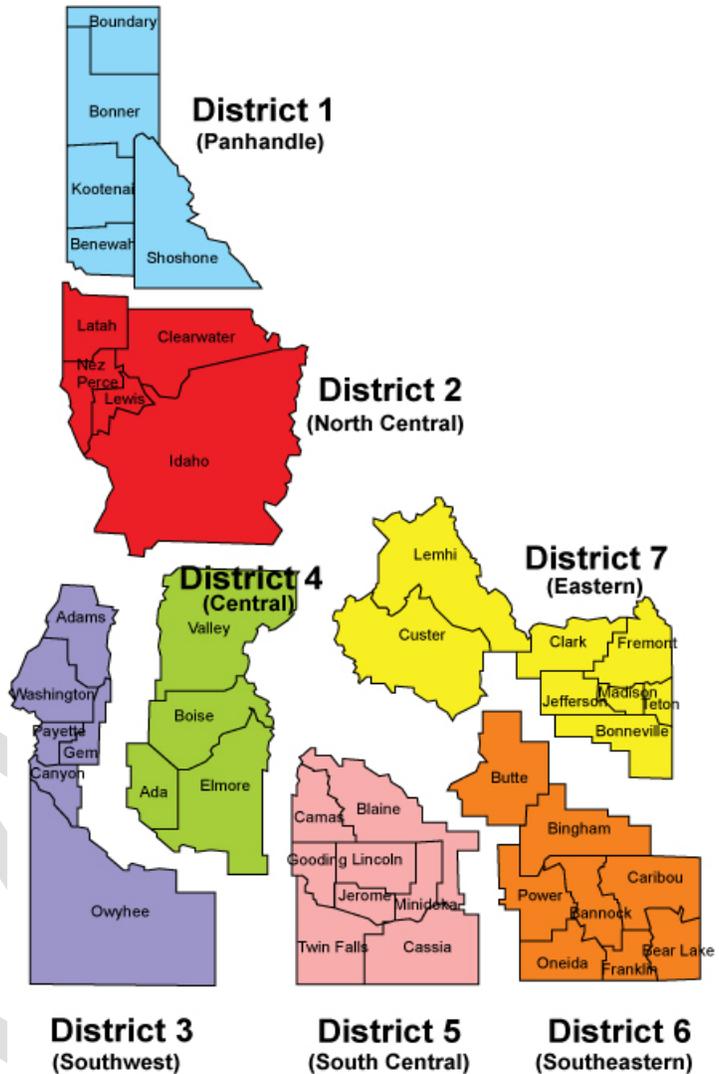


Figure 1: Map of Idaho Public Health Districts

Overview of Current Mentorship Activities in Idaho

Throughout the seven PHDs, mentorship has either been discussed or is informally happening with SHIP clinics through the RCs or through the PHD SHIP staff. In the North Central Healthcare Collaborative, mentorship has been discussed as a major purpose of the RC. In the Southwest Health Collaborative, mentorship has not been discussed formally but they do support professional networking. The Central Health Collaborative expressed that

there is a great need for mentorship across clinics and systems. In addition to the technical assistance and support of the PCMH Team coaches from Health Management Associates (HMA) and PHD SHIP Quality Improvement (QI) Specialists, they have discussed the need specifically within the Central Health Collaborative, primarily in the form of PCMH transformation workgroups. The idea is that care coordinators, managers, medical assistants, etc. from Cohort One and Cohort Two clinics would be convened to help one another through the transformation process through by information sharing, best practices, electronic health record (EHR) transitions and utilization, etc. In the South-Central Health Collaborative, clinics and their PCMH teams have been mentoring each other from the beginning of the SHIP. Early on, Dr. Keith Davis, the RC Chair, went to each Cohort One clinic site to observe and aid in PCMH transformation. The Eastern Health Collaborative does not specifically define mentorship, however, they commonly use the RC to share best practices, to provide an opportunity to ask questions, and to receive help from other clinics. Similarly, the Southeastern Health Collaborative has actively engaged in mentorship opportunities, but has not clearly defined or structured them. Dr. Mark Horrocks, Co-Chair of the Southeastern Health Collaborative, has engaged Cohort One and Cohort Two clinics by fostering opportunities to deliver and facilitate discussions with clinic staff members from participating SHIP clinics to aid practices that are beginning PCMH transformation. Lastly, the Panhandle Regional Collaborative provides mentorship opportunities through PCMH meetings. These regularly scheduled meetings offer an educational portion of the meeting where one clinic presents on an identified topic area that can benefit other attendees and follows with a questions and answer session.

Mentoring activities have organically formed in the RCs but the structure varies from district to district. The North Central Healthcare Collaborative currently has a few of their SHIP clinics assisting other SHIP clinics in their implementation of, not only PCMH initiatives, but also the sharing of best practices for QI projects and other clinic programs (e.g. Transitional Care Management, Chronic Care Management, Behavioral Health Integration). Similarly, the Panhandle Regional Collaborative varies the format of their RC meetings to offer rotational groups for each clinic team in attendance. They have touched on topics such as care management, care coordination, and team based care allowing each group to begin the conversation informally. The Southwest Health Collaborative convenes a monthly PCMH workgroup that is open to all primary care practices, in addition to Cohort One and Cohort Two clinics. Healthy Connections also participates in the workgroup. The workgroup identifies a local subject matter expert (SME) for a certain topic and that individual presents to the group and takes questions. Mentorship has not been set in motion throughout the Central Health Collaborative via a formalized process. However, it is being done across clinics and systems in different ways. Specifically, the PHD QI Specialist is connecting clinics to one another based on a specific area of need that one clinic may have and connecting that clinic with another clinic that may be more advanced in that area of transformation. As a region, the Central Health Collaborative has also connected Community Health Worker (CHW) coordinators or outreach/promotion coordinators with clinics who are interested in hiring a CHW, to help them learn more about how to implement a CHW role in a primary care setting. Additionally, PHD staff also spend time connecting clinics with the same EHR, to discuss how to improve utilization and overall tips and tricks for best use of the system. Lastly, it has been found that surveying clinics on their knowledge of local resources within the Medical-Health Neighborhood seems to work well to connect clinics to existing resources that they may not be aware of in the community. Currently, in the South Central Health Collaborative, clinics are represented within the RC and frequently provide insight into success or challenges. Cohort Two clinic representatives attend monthly RC meetings and share what is occurring in their practices. The clinics maintain open lines of

communication with each other; specifically, emailing information from clinic to clinic has been successful. As previously mentioned, Dr. Davis, has been helping in PCMH transformation even before the inception of SHIP. The Eastern Health Collaborative does not specifically define mentorship, however, they commonly use the RC to share best practices, to provide an opportunity to ask questions, and to receive help from other clinics. Clinics have reached out to each other to set up either behavioral health connections, work on an EHR fix, or to share thoughts on chronic care management programs.

The Southeastern Health Collaborative is divided into three different meetings: executive, clinic, and the Medical-Health Neighborhood. The clinic committee meeting allows members from the cohort clinics to discuss their challenges and barriers while also discussing tips, previous experiences, and suggestions to solving problems on a quarterly basis. During Cohort One, the clinic committee meeting was held in clinic locations of those who were already PCMH recognized. This allowed non-recognized clinics an opportunity to see how recognized PCMH clinics offered services, structured their clinic, and how the clinic delivers and streamlines its services on a day-to-day basis. Job descriptions and work flow strategies have also been shared between clinics and job shadowing opportunities continue to occur. The Medical-Health Neighborhood meeting, as part of the Southeastern Health Collaborative, has allowed both clinical and non-clinical partners to convene and collaborate on existing health disparities in regionally. These relationships also provided opportunities for staff to learn about existing resources within the region and how other clinics have utilized their own resources to meet patients' needs.

Many mentoring activities are currently happening or are have been proposed to happen within SHIP. Peer-level support that clinics can offer to each other is a crucial element of PCMH transformation. Creating a strong network of "champion" clinics that can serve as mentors to other clinics is an important part of the model. The PCMH Transformation Team, consisting of Brilljent and HMA, along with the PHD SHIP QI staff will recruit up to three practices to serve as champions during the current cohort year. Ideally the champions will represent different practice proficiency levels. They will participate in training activities such as the learning collaborative, providing examples of their experiences and encouragement to new practices.

The WWAMI (Washington, Wyoming, Alaska, Montana and Idaho) Medical Education Program and the Idaho State-level Evaluation Team are coordinating administrative and curriculum resources to develop Continuing Education Unit (CEU) opportunities for SHIP clinics on value-based healthcare and other topics related to PCMH. The Idaho WWAMI program aligns closely with the achievement of the Triple Aim and many goals of SHIP.

The curricular materials will also be used in the Idaho WWAMI medical curriculum. A good portion of the curricular material will draw on the cumulative experiences of the SHIP cohort clinics in implementing a PCMH model of care in the clinical and cultural contexts of Idaho primary care clinics. Interactive on-line modules will be developed with incorporation of provider and patient testimonies about the development and use of PCMH as appropriate. The VA Office of Academic Affiliations - Centers of Excellence in Primary Care Education (CoEPCE) have developed courses via an online sharing platform created for PCMH teaching clinics affiliated with the VA. Courses available in 2017 include huddles, population/panel management, and strategies for managing geriatric polypharmacy. One example already offered on the website is a "hot spotter" case conference for high-needs, high-utilization patients called PACT ICU (Patient Aligned Care Team Interdisciplinary Case Unit). Others

courses currently in development include shared medical appointments, panel management of narcotic pain medications, and primary care/mental health integration models.

The Idaho Integrated Behavioral Health Network (IIBHN) developed in 2016 as a professional learning collaborative designed to enhance and support the growth of integrated behavioral health programs to assist in team-based care management of co-morbid medical and behavioral health conditions in primary or specialty care clinics. The network began and is supported by behavioral health leaders from IDHW's Division of Behavioral Health, Family Practice Residency of Idaho, Terry Reilly Health Services, and St. Luke's Health Partners in collaboration with Southwest District Health and Central District Health. The network identified that the work demands of behavioral health consultants (BHCs), social workers, and counselors, are unique within the world of mental health. BHCs may also encounter some professional isolation as there are a limited number of BHCs in Idaho. Additionally, the Primary Care-Mental Health Integration community is inter-professional, so typical outlets for connecting with like-minded professionals can be challenging. In southwestern Idaho, the IIBHN held three BHC "get togethers" in 2016 that involved clinical discussion geared toward behavioral health integration occurring in clinics. The IIBHN will work through 2017 to create chapters within other regions of Idaho to have similar collaborative meeting with other BHCs across the state. Beginning June 2017, Southwest District Health and Central District Health will begin transitioning facilitation of regional or hub IIBHN meetings from St. Luke's Health Partners.

Several regions have identified barriers to implementing a more formal mentorship plan statewide. One identified risk could include clinics not having a vested interest in becoming mentors; there may be territorial or competitive challenges; implementing a more formal structure may restrict or redirect what is presently occurring; clinics may feel that the technical assistance support they receive through SHIP meets their current needs. Clinic needs can be very specific. Additional barriers at the clinic level include scheduling time for mentoring/training, insufficient time to dedicate to mentorship, and lack of leadership support.

Mentoring Needs under SHIP

This framework is intended to assist in the development of a peer-to-peer support system to support SHIP cohort clinics in system change, PCMH transformation, data quality, and additional tasks related to their SHIP participation and the larger efforts involved in healthcare reform. This framework can also be utilized by primary care clinics outside of SHIP, as they may likely participate in similar efforts of a support relationship with other practices. Mentoring focuses on the clinic relationships, commitments, and resources that help clinics find success and fulfillment in their PCMH transformation pursuits. At the VA Office of Academic Affiliations CoEPCE annual meeting in San Diego, April 25-27, 2017, attendees defined mentorship as a personal and reciprocal relationship between two parties. They went on to further explain that it is typically formed between experienced and less-experienced clinics and is usually achievement-focused.

Mentoring helps clinics understand how their ambitions fit into broader system change, leadership and staff engagement, PCMH principles, and continuous transformation efforts. As clinics progress through PCMH transformation, they will find that rarely is one clinic or peer able to meet all their mentoring needs. It may be necessary for primary care clinics to identify multiple mentors or subject areas in which to obtain effective guidance from peers. Mentoring is also a relationship without judgement. Together clinics partake in iterative

problem solving aimed at specific achievements, mentoring with resource connection and with change occurring in a positive direction.

A novice clinic may be a clinic which has had little or no exposure to PCMH concepts. Clinic leadership may be engaged and initiating early discussion regarding transformation, but may not have informed the rest of the clinic staff in the conversation. These clinics may have developed PCMH teams, and have engaged leadership, but are still putting things in place to begin transformation efforts. A mature clinic may be a clinic which has progressed through PCMH transformation and is continually making improvements based on the PCMH model. They may or may not be nationally accredited or recognized in PCMH, but they are proven to be doing “the work”. Practices may identify as novice or mature in different areas. Clinics identify their level and the areas in which they feel they may need assistance. Peer-to-peer supports should also be in place that involve practices that are at similar levels of transformation and are seeking additional support from each other. This may involve brainstorming session on how to move past topics where they feel “stuck” or may involve advisement through the PCMH accreditation process, etc.

Many practice needs for mentorship are similar regardless of level of experience with the PCMH model. Practice teams learn by expanding PDSA cycles, and by accomplishing goals together as opposed to listening and reading transformation-related topics. Learning collaboratives and PCMH-related educational webinars lay a foundation for training in PCMH principles and concepts areas. Matching clinics by needs and resource is a way to generate further and continued collaboration amongst primary care teams.

Clinics participating with SHIP have additional resources such as technical assistance through the PCMH Team and specifically with the SMEs from HMA. These coaches act as advisors to selected SHIP clinics, providing the clinical experience and knowledge but acting more as a monitor or coach overseeing the clinic’s transformation efforts. While advisement can be equally as important to change and transformation as mentorship, an advisor is not fitting to the peer definition related to mentoring. The recent VA CoEPCE annual meeting also defined an advisor as a person fulfilling program and advisee needs, frequently serving a dual role that may involve assessment in which they see themselves as an evaluator or administrator. Mentoring offers more opportunity for flexibility within the relationship between the clinic teams than advising does on a more individual or job role basis.

Primary care practices obtain many benefits from a successful mentoring relationship. Mentoring enables clinics to acquire skills and knowledge on specific transformation topics; it helps teams develop techniques for collaborating and networking; it helps engage the curiosity and energy of passionate healthcare professionals; it prepares the next generation of patient-centered focused primary care practice; it allows clinic teams to enjoy the personal and professional satisfaction integral to mentoring relationships.

Recommendations

The PCMH Mentorship Subcommittee devised multiple strategies that have worked elsewhere regarding peer-to-peer support or areas they saw that were needed to assist practices and providers across the state. One suggestion was to create a mentorship matching in certain topic areas. This would involve surveying practices based on clinic setting, areas of interest, or characteristics of populations served to help connect practices and

allow them to get the professional guidance and knowledge they need to succeed in their transformation efforts.

Additional strategies the Subcommittee suggested to address within primary care practices were data related – including EHR usage and health information exchange, team-building, and empanelment. Another suggestion was to create a “master list” comprised of subject areas for clinics can assist each other with. Subjects identified include:

- EHR systems,
- care coordination,
- behavioral health integration,
- team-based care,
- national accreditation application processes,
- Idaho Health Data Exchange (IHDE) connectivity,
- performing huddles,
- chronic care management, and
- collaboration with specialty care practices

The State of Idaho has a rare opportunity to expand upon the collaboration of participating SHIP clinics, the RCs, and the PCMH Mentorship Subcommittee members. The PCMH Mentorship Subcommittee, along with the IMHC Workgroup and the IHC, has identified the following recommendations for maintaining relationship building efforts and mentorship amongst primary care practices within the State of Idaho during the SHIP initiative and beyond.

Recommended Resource	What needs to happen?	Possible Facilitator/Holder
<p>Resource Guide</p> <ul style="list-style-type: none"> • Recommendations and guidance to shape resources/tools/materials that will support PCMH mentorship 	<p>The State Evaluation Team has already offered assistance in this development. Recommended to include resources about Bodenheimer’s 10 Building Blocks of Primary Care, Safety Net Medical Home, PCMH principles, Project ECHO network information and module topics list through UI WWAMI Medical Education Program.</p>	<p>RCs; State Evaluation Team; state universities</p>
<p>Provider Champion Mentor Panel</p> <ul style="list-style-type: none"> • To assist in identifying and operationalizing priority areas related to PCMH and mentorship 	<p>Convene and facilitate a Champions discussion to prioritize the basics of mentorship and operationalize a framework that the state can commit to.</p>	<p>IDHW</p>
<p>Mentorship Webinar Series</p> <ul style="list-style-type: none"> • Subject-based webinars on common issues experienced by SHIP cohort clinics throughout the state. May include topics such as: EHRs, data and pulling reports, huddles, like-clinical roles (i.e.: IT/data staff, CHWs, Care Managers). 	<p>IDHW is in discussion with PCMH Contractor to establish frequent webinars facilitated by a SME to follow and “Ask & Give” format for a peer-to-peer/ clinic-to-clinic learning experience.</p>	<p>IDHW</p>

<p>Master List</p> <ul style="list-style-type: none"> • Checklist of clinics that have similar EHRs, care coordination, BHI, team-based care, national accreditation application processes, IHDE connectivity, huddles, chronic care management, creating MOUs or BAs for collaboration with specialty care practices. 	<p>Survey clinics to create an inventory list/ checklist to be utilized by PCPs, PHDs, RCs, Healthy Connections, etc. to grasp who is doing what and how to build relationship between clinics, providers and clinical teams.</p>	<p>PHDs; RCs; State Evaluation Team</p>
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ⁱ <http://www.unl.edu/mentoring/introduction>

ⁱⁱ <http://www.parkinson.org/expert-care-research/centers-of-excellence/mentoring-program>

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