NH CITIZENS HEALTH INITIATIVE
ANNUAL SYMPOSIUM
CONNECTING THE PIECES OF WHOLE-PERSON CARE

Wednesday, September 25th, 2019
8:30 am – 3:00 pm

#WholePersonCare19
Today’s Agenda

8:30-9:00  Registration & Networking

9:00-915  Welcome
  Mike Ferrara, PhD, ATC, College of Health and Human Services, UNH

9:15-10:40  My Pieces May Fit Differently Than You Think
  Tanya Lord, PhD, MPH, Foundation for Health Communities
  Introduction by: Jan Thomas, RN, BS, NH Citizens Health Initiative

10:40-11:00  Debrief and Group Discussion
  Tanya Lord, PhD, MPH, Foundation for Health Communities

11:00-11:15  Networking Break

11:15-12:15  Breakout Sessions

12:15-1:00  Lunch

1:00-2:25  Patients as Partners in Transformation in the Rural Setting
  Mary Reeves, MD, Transforming Clinical Practice Initiative
  Introduction by: Jo Porter, MPH, Institute for Health Policy and Practice

2:25-2:50  What’s Coming Up
  Marcy Doyle, DNP, MS, MHS, RN, CNL, NH Citizens Health Initiative
  Holly Tutko, MS, NH Citizens Health Initiative

2:50-3:00  Closing
  Jeanne Ryer, MSc, EdD, NH Citizens Health Initiative
Planner Disclosure

The following planning committee members from the Citizens Health Initiative at the Institute for Health Policy and Practice at the University of New Hampshire have responded that they have nothing to disclose:

• Katherine Cox, MSW, Project Director
• Kelsi West, BS, Research Associate
• Annie Averill, BA, Research Associate
• Jeanne Ryer, MSc, EdD, Director
• Felicity Bernard, MA, LCMHC, Project Director
• Hwasun Garin, MEd, Project Director
• Corina Chao, BA, Research Associate
• Khloe O’Brien, BS, Research Associate

The following planning committee members have responded that they have nothing to disclose:

• Frederick Kelsey, MD, FACP, Medical Director Emeritus, Mid State Health Center
• Laura Remick, MEd, CHES, Workforce and Education Coordinator, North Country Health Consortium
• Jill Gregoire, MSN, RN, Nurse Planner, North Country Health Consortium
Presenter Disclosure

The following individuals have responded that they have nothing to disclose:

• **Felicity Bernard, MA, LCMHC**, Project Director, Citizens Health Initiative at the Institute for Health Policy and Practice at the University of New Hampshire
• **Katherine Cox, MSW**, Project Director, Citizens Health Initiative at the Institute for Health Policy and Practice at the University of New Hampshire
• **Alexa Trolley-Hanson, MS, OTR/L**, Clinical Assistant Professor, UNH Department of Occupational Therapy
• **Tanya Lord, PhD, MPH, Director**, Patient and Family Engagement, Foundation for Healthy Communities
• **Mary Reeves, MD, MS**, National Faculty, Transforming Clinical Practice Initiative
• **Delitha Watts, AS, LSSBB**, Practice Facilitator, Citizens Health Initiative at the Institute for Health Policy and Practice at the University of New Hampshire
• **Jennifer Lesieur, MS, LCMHC**, Director of Quality Improvement and Corporate Compliance, Center for Life Management
• **Danielle Louder, BS**, Director, Northeast Telehealth Resource Center; Co-Director, MCD Public Health Medical Care Development
• **Carol Furlong, LCMHC, MAC, MBA, MS**, Director of Substance Use Disorder Services, Elliot Hospital
• **Stephen Del Giudice, MD**, Co-founder, NorthernSky Healthcare Consultants
• **Samantha Captain**, Peer Support Team Leader, Psychiatric Emergency Services, Riverbend Community Mental Health
• **Jennifer Chisholm, LICSW, MLADC**, Behavioral Health Coordinator, Health Care for the Homeless, CMC
Presenter Disclosure

**Stephanie Nichols, Pharm.D., BCPS, BCPP, FCCP**, Associate Professor of Pharmacy Practice, University of New England College of Pharmacy has disclosed that she has worked with the American Academy of Family Physicians on development of an ADHD Toolkit. This work was funded by a grant from the manufacturer of lisdexamfetamine.

Dr. Nichols will not be discussing this research project or this manufacturer as part of her presentation for this event.
Learning Objectives

After participating in this activity, learners will be able to:

• Identify opportunities to make health care more person-centered

• Describe evidence-based practices to enhance whole-person care.

• Apply interdisciplinary approaches to promote whole-person care.
LEARNING CREDITS – COMPLETE EVALUATION

Complete the online survey to receive credit
https://www.surveymonkey.com/r/evalCHI2019symposium
*Links to the evaluation will be sent out after Symposium

Medical:
The North Country Health Consortium/NNH AHEC is accredited by the NH Medical Society to provide continuing medical education for physicians. The North Country Health Consortium/NNH AHEC designates this live activity for a maximum of up to 4.0 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Nursing:
North Country Health Consortium/NNH AHEC is an Approved Provider of continuing professional development by the Northeast Multistate Division, an accredited Approver by the American Nurses Credentialing Center’s Commission on Accreditation. This activity has been approved for up to 4.0 Nursing Contact Hours. Activity #442.

Social Work:
This program has been approved for 4.0 Category A Continuing Education Credits by the National Association of Social Workers. NH Chapter CEU# 3624.

For Other Professionals:
Up to 4.0 Professional Hours of Continuing Education.
Please silence phones and pagers
INTRODUCTION TO KEYNOTE:
JAN THOMAS, RN, BSN

Project Director
NH Citizens Health Initiative
Institute for Health Policy and Practice
University of New Hampshire
Presenter Disclosure

The following individual has responded that they have nothing to disclose:

• Tanya Lord, PhD, MPH, Director, Patient and Family Engagement, Foundation for Healthy Communities
My Pieces may Fit Differently Than you Think

Tanya Lord  PhD, MPH
Director, Patient and Family Engagement
Foundation for Healthy Communities
tlord@healthynh.org
What words have been used to describe you?
What are your first thoughts when you hear these words?

- White American Mother
- Morbidly Obese
- Drug Addict
- Trump Supporter
How do people behave when they believe these thoughts?

1. White American Mothers are all the same
2. Morbidly obese people do not care about their health
3. Drug addicts are not worth saving
4. Trump supporters are stupid
White American Mother
Morbidly Obese
weight loss is more than a physical challenge, it's a mental challenge.
Drug Addict
You didn’t CAUSE it. You can’t CURE it. You can’t CONTROL it.

YOU CAN...
TAKE CARE OF YOU, COMMUNICATE YOUR FEELINGS, ALLOW OTHERS TO HELP, AND SET BOUNDARIES.
Trump Supporter
I DON'T ALWAYS TALK TO TRUMP SUPPORTERS

BUT WHEN I DO I MAKE SURE TO SPEAK AT A 3RD GRADE LEVEL
We all have thoughts like these that we believe about people
Why Does This Happen?

It all depends on how the pieces are put together and the beliefs we have behind each one.
What would happen if we were incapable of believing them?
We Would Listen!
We Would Listen!

• To Ourselves
• To Each Other
• To Those we Serve
• To Populations
Listen to Ourselves

- Observe our beliefs of others
- Identify implicit biases
- What is your self-talk?
- Practice self compassion
Self-Compassion

Treating ourselves with the same kindness as we would treat a dear friend
Self Compassion Practice

Identifying the emotion or point of suffering.

- This is a moment of suffering

Recognize the common humanity within the suffering.

- Suffering is a part of life. I am not alone in this
- This is a normal human reaction - others feel like this in similar circumstances

Offer ourselves kindness and compassion in the midst of our pain.

- May I be kind to myself
- What would I say to a close friend in similar circumstances
Listen to Each Other

- What do we know about our co-workers?
- What is important to know about them?
- Do we provide the right kind of support and compassion?
- Provide space for self reflection
Listen to Those we Serve

• We can never become competent in someone else’s:
  • Journey
  • Culture
  • Lifestyle
  • Choices
  • Hopes
  • Desires

• Cultural Humility can be expanded professionally and personally
Cultural Humility Factors

- Self-reflection and the Lifelong Learner Model
- Fix power imbalances
- Community-based care and advocacy

Source: Tervalon & Murray-Garcia, 1998
Self Reflection and Lifelong Learning

• Commit to lifelong reflection as we change based on our experiences

• Consciously assess implicit bias, personal beliefs

• Avoid the false sense of security in one’s training (stereotyping)

• Say that you do not know when you truly do not know
Fix Power Imbalances

• Acknowledge the power differential

• Use patient centered interviewing

• Relinquish the role of sole expert, become the student of the patient
Community Based Care and Advocacy

- Develop partnerships with people and groups within the community
- Experience with the community the factors at play in defining health priorities, research activities and community-informed advocacy
- Identify, believe in and build on the assets and adaptive strengths of communities and their members
Ask Questions to Learn

- What do you want me to know about you?
- What matters to you?
- What has happened to you?
- What do you need to make this comfortable?
- When have you had success?
- What frightens you the most?
- What are you most looking forward to when “this” is over?
Listen to Populations

• Engage Patients and Families
• Experienced Based Co-Design
  • Include to all voices
Experienced Based Co-Design (EBCD)

An approach that enables staff and patients (or other service users) to co-design services and/or care pathways, together in partnership.
We need to be aware

...of our own biases and withhold our own judgment about what the patient and family say and choose. Our job is to inform, facilitate, and advocate. It's not to make decisions for them.
Approach your Beliefs with Curiosity

- Is it true?
- Can you know that it is true?
- How do you behave when you believe it?
- How would you behave or who would you be without that thought?

The Work by Byron Katie: [https://thework.com/](https://thework.com/)
Peace is our natural condition

Without the pull of our beliefs the mind stays serenely in itself and is available for whatever comes along

~Byron Katie
What Impact can we Have?
Putting The Pieces Together
A Unified Team
Thank you
Questions?

Tanya Lord PhD, MPH
Director, Patient and Family Engagement
Foundation for Healthy Communities
tlord@healthynh.org
Debrief
How was this for you?
Questions for me?
Draw an Iceberg

What can be observed?

What cannot be observed?
Nods to indicate agreement or understanding

PhD, MPH

Death is not a failure or the end

Strong Faith

First Generation American

Educational Bias

Peace Corps

June

Practices many memorial rituals

Terrified Patient or Family member

Deep belief in equity and partnership

Things happen for a reason
Share with someone something that is at the bottom of your iceberg.
Thank you!

Resources:
1. Byron Katie: https://thework.com
2. Self Compassion: https://self-compassion.org

Tanya Lord PhD, MPH
Director, Patient and Family Engagement
Foundation for Healthy Communities
tlord@healthynh.org
# Morning Breakout Sessions

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<th>BREAKOUT SESSION</th>
<th>ROOM</th>
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<td>Provider Resiliency: Contributing Factors, Impact, and Solutions Panel Discussion</td>
<td>Webster</td>
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<tr>
<td>The Power of “Doing”: How Enabling Engagement in Meaningful Life Activities Leads to Patient Health and Wellness</td>
<td>Concord</td>
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<td>Removing the Fear of Change: Strategies for Developing a Continuous Improvement Culture</td>
<td>Pierce</td>
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<tr>
<td>Telehealth and Project ECHO: “Connected” Care for Improved Outcomes</td>
<td>Merrimack</td>
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</table>
INTRODUCTION TO KEYNOTE:
JO PORTER, MPH

Director
Institute for Health Policy & Practice
University of New Hampshire
Presenter Disclosure

The following individual has responded that they have nothing to disclose:

• Mary Reeves, MD, MS, National Faculty, Transforming Clinical Practice Initiative
PATIENTS AS PARTNERS
IN TRANSFORMATION
IN THE RURAL SETTING

MARY REEVES MD
TCPI NATIONAL FACULTY

NH Citizens Health Initiative Symposium
September 25, 2019
Concord, NH
OBJECTIVES

1. Discuss applying principles of practice transformation to the unique characteristics of a rural practice.

2. Learn how patient family advisory councils (PFACs) can be implemented in health care settings.
AGENDA – THE INTERSECTION OF SDOH & PRACTICE TRANSFORMATION IN A RURAL SETTING

I. My personal experience starting a PFAC – lessons learned

II. Why and how to partner with patients

III. Changing Culture – intent, tools and sustainability
TODAY’S AFTER LUNCH/STAY AWAKE PLAN

✓ A Question to “run on”
✓ Short presentations
✓ Engaged audience with time to Share your thoughts on the Question
✓ = Leave in Action
WHO IS IN THE ROOM?

the RURAL LENS
How would I start a PFAC?
or
What lessons have I learned from my PFAC?
I STARTED OUT AS A PFAC SKEPTIC!
First Street Family Health (FSFH)

http://www.firststfamilyhealth.com

- Rural 4 doctor, 2 PA physician-owned Family Medicine Clinic in Salida, Colorado.
- We have 8400 empanelled, risk stratified patients.
- Transformation since 2012 with CPCi (Comprehensive Primary Care initiative) – now, thriving in CPC+ track 2
- PFAC started August 2014
- Case study for AHRQ - *Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families*

And me...

- I practiced full spectrum Family Medicine at FSFH from 1993 – 2015 (now retired)
- Physician lead for CPCi 2012 – 2015 --> realized value of PFAC for our practice
- National Faculty for TCPI since December 2015 --> realized value of PFE as a national strategy for transformation

https://edhub.ama-assn.org/steps-forward/module/2702611?resultClick=1&bypassSolrId=J_270
RESOURCES – AMA
STEPS FORWARD MODULE

Forming a Patient Family Advisory Council (PFAC)

https://edhub.ama-assn.org/steps-forward/module/2702594?resultClick=1&bypassSolrId=J_2702594
PFAC: HOW WE GOT STARTED

- National Partnership for Women and Families provided us with the foundation and structure to begin.
- Identified practice members for the council including 1 physician, 1 RN care coordinator, one member from front office, back office and MA staff.
- Recruit patient/family members with focus to fairly represent populations in regards to payer source, age, gender, ethnicity, etc.
- Create ground rules re: confidentiality and meeting protocol, etc.
3 MONTHS LATER, THE FIRST PFAC MEETING

- The PFAC identified issues that were important to patients & the practice and worked together to solve them. The first project will set the tone and build confidence and trust.

- Some topics were generated by the patients and some by the practice

- **Now**— anytime an issue comes up in the practice, we start by “running it by the PFAC” for input.
FSFH PFAC: HOW IT WORKS

- We met monthly at the beginning to get off to a good start, now we meet quarterly.
- Meeting - 5:30-7 pm in a community space provided by one of the members
- Food! Best chance of participation if you feed us!
- Daycare provisions help
5 YEARS LATER...OUR PFAC IS A VALUABLE PARTNER AT FSFH

- Started by solving a persistent front desk phone reception problem
- Re-vamped new patient forms
- Perform regular clinic walk-throughs
- Re-designed our website
- Currently working on Diabetes QI projects

NEXT...?
What excites me about what I’ve heard?

Take a few minutes to talk together. Then, we’ll explore our ideas & plans as a group.
How would I start a PFAC?
or
What lessons have I learned from my PFAC?
#2

How am I already engaging with patients?

and

What new way to partner with patients would I like to try?
WHY & HOW TO PARTNER WITH PATIENTS (IN A RURAL AREA)
WHY PARTNER W/ PATIENTS AND FAMILIES?

- Bring important perspectives
- Teach how systems really work
- Keep staff grounded in reality
- Provide timely feedback and ideas
- Inspire and energize staff
- Lessen the burden on staff to fix the problems... staff do not have to have all the answers
- Bring connections with the community
- Offer an opportunity to “give back”
- Prioritize precious resources
MORE REASONS TO PARTNER...

- By definition – the patient perspective on your practice
- Partnership is superior to hiring consultants
- Putting patients first is always the most practical investment providers can make to transform their practices. (Best ROI)
- Accelerates Practice Transformation
- Best way to increase patient or family member’s health literacy and engagement
- Prevent burn-out
“Patients and their families are an abundant source of wisdom as we navigate the stormy seas of health care delivery. To go it alone without their partnership is foolish and unwise. With patients as equal partners in the journey of health care transformation, our work together is more fulfilling, more meaningful, and more likely to help them reach their health goals.”

Dr. Joseph Bianco, MD, FAAFP, Director of Primary Care for Essentia Health
PARTNERING TRANSFORMS EVERYTHING

- My transformation from skeptic to spokesperson
- Improved operational performance
- Low cost – high value
- Engaged patients have better outcomes
- Patients take the transformation out of the practice
- This new normal is transforming U.S. healthcare system
A KEY LEVER 4 LEADERS IN PRACTICE TRANSFORMATION

“In a growing number of instances where truly stunning levels of improvement have been achieved... Leaders of these organizations often cite—putting patients and families in a position of real power and influence, using their wisdom and experience to redesign and improve care systems—as being the single most powerful transformational change in their history.”

SO, LET’S CHANGE THE ASSUMPTIONS

**Assume patients** are the experts on their own experience & that they have information you need to hear and act on.

**Understand** that families are primary partners in a patient’s experience and health.
## OPPORTUNITIES TO PARTNER W/ PATIENTS

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<tr>
<th>Opportunity</th>
<th>Examples</th>
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<tbody>
<tr>
<td>1. At the Point of Care</td>
<td>Shared decision-making</td>
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<td>Safe medication use, “med” management</td>
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<td>Patient “activation”</td>
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<td>Patient Portal</td>
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<td>2. In the Community</td>
<td>Wellness programs</td>
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<td>Support groups</td>
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<td>Community partnerships</td>
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### MORE OPPORTUNITIES TO PARTNER W/ PATIENTS

<table>
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<tr>
<th>Opportunity</th>
<th>Examples</th>
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<tr>
<td>3. At the Organizational Level</td>
<td>PFACs, patient surveys, Serving on the Board of Directors, Care process mapping, Clinical QI teams, oversight, strategy, Informing best practices</td>
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<tr>
<td>4. Contributing to Public Policy</td>
<td>Partnering with advocacy groups, public health &amp; government affairs, publishing</td>
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THE VALUE OF A PFAC

- Adds a “department” to a practice totally devoted to improving the practice.
- Provides the infrastructure to bring patients into partnership for transformation – assuring patient centered efforts and accelerating transformation.
- PFAC started 8/2014 has generated operational process improvements totaling > $100,000
ONE LAST EXAMPLE...

Partnering with patients to improve health care

Patrick Conway gave an example of a hospital policy that required IV antibiotics for children with osteomyelitis, despite evidence of equal efficacy using orals (and significantly less cost and trauma). He could not change this policy through the usual channels. But, a Shared Decision Aid did the trick as 98% of parents chose oral antibiotics.
What excites me about what I’ve heard?

Take a few minutes to talk together. Then, we’ll explore our ideas & plans as a group.
#2

QUESTIONS TO RUN ON

How am I already engaging with patients?

and

What new way to partner with patients would I like to try?
#3

QUESTIONS TO RUN ON

Can you see the intersections?

and

How will you leave in action?
CHANGING THE CULTURE & GETTING PAID FOR IT
THE CULTURE OF PRACTICE TRANSFORMATION

• How do you change the culture of a practice?
• Need the change of culture that Practice transformation provides and patients spur on
• How do you partner with patients?
• SDOH as a partnering mechanism, PFAC as infrastructure
• APMs as the payment mechanism
RESOURCES – PCPCC
PATIENT CENTERED PRIMARY CARE COLLABORATIVE

6 Steps to Creating a Culture of Person and Family Engagement in Health Care – a Toolkit for Practices

Our 5 year journey through transformation

60+ yo Traditional Medical Practice

Improving Performance

- Empanelment
- Risk Stratification
- Care Management
- Team Based Care
- Learn to Use the Data
- Two Areas of Performance
- Patient-Family Advisory Council

Commitment and funds (CPCI)

Year 1

- Advanced Practice

Year 2

Years 4+
Sustainable business (CPC+)

Advanced Primary Care Practice
HOW IT WORKED

INVEST in people and infrastructure with CPCI funds – an additional 13% of budget.

IMPROVED PERFORMANCE through care management, population health, care team redesign.

Partnering w/ Patients strategies are a low tech/low cost way to accelerate the process of transformation.
TIMELINE OF TRANSFORMATION

2011 – 2015
Transformation
Comprehensive Primary Care Initiative

1950 – 2011
Old Way
Traditional small town doctor’s office

2016 Forward
New Way
CPC+ an Advanced APM

FFS

FFS + PMPM

FFS (w/ increasing risk) + PMPM + Incentive payments
Teams are key – Clinical teams and Practice teams are a new way to care for patients and run a practice

Payment is complex – Care Management Fee is risk adjusted PMPM payment, Performance Based Incentives linked to pt. exp., CQMs and utilization, and FFS w/ a portion at risk

Data drives everything - > 85% benchmark on all measures qualify for higher payment levels, access data reviewed in huddles weekly, falls

Access – multiple care paths allow the practice to remain open to new patients

Patient Voice – PFAC meets quarterly and is an integral part of the practice
SUSTAINABILITY = PAYMENT REFORM + JOY IN WORK

Payment Reform because it’s not possible to transform practice to a patient centered culture on the current “hamster wheel” of FFS.

and

Joy in Work because it’s not possible to sustain the work if the workforce is burned out.

WE NEED TOOLS FOR BOTH
Practice transformation is necessary to succeed in APMs (payment reform).

Partnering with patients accelerates practice transformation.

Partnering with patients promotes joy in work.
PARTNERING WITH PATIENTS IS SUCH A TOOL

- Partnering with patients accelerates practice transformation
- Partnering with patients promotes joy in work
- Partnering with patients both relies on and improves their Health Literacy
Patient & Family Engagement: Central to QPP Success

Quality Payment Program—
- Quality Measures (60% of MIPS score)
  - Patient experience
  - Medication management
  - Functional status
  - Advanced Care Plan
- Advancing Care Information (25% of MIPS score)
  - Patient portals, Summary of Care, e-Prescribing, patient-specific health education
- Improvement Activities (15% of score)
  - Engage patients and families to guide improvement in the system of care
  - Regularly assess the patient experience through surveys, advisory councils and/or other mechanisms
  - Shared decision making

QPP is a mechanism to pay YOU for value.
HEALTH LITERACY IS SUCH A TOOL

- Health Literacy is critical to Shared Decision-Making – which is the basis of the patient/clinician partnership
- Partnering with patients both relies on and improves their Health Literacy
- Improvements in Health Literacy provides value to the Patient and the Practice
THE SDOH IS SUCH A TOOL

Addressing the SDoH is a way to:

• “partner” with the community
• to better care for patients
• that provides a high ROI for the practice
WHAT IS THE RETURN ON INVESTMENT?

- Increased patient engagement and satisfaction
- Reduced ER visits
- Reduced re-admissions
- Better screening and care of chronic diseases
- Decreased medication errors

ALL IMPORTANT METRICS IN APMs
America’s Blind Side

The Overlooked Connection between Social Needs and Good Health

FINDINGS...

• 4 in 5 physicians surveyed (85%) say patients’ social needs are as important to address as their medical conditions

• 4 in 5 physicians surveyed (80%) are not confident in their capacity to address their patients’ social needs

• 3 in 4 physicians surveyed (76%) wish the health care system would pay for costs associated with connecting patients to services that address their social needs
RESOURCES – AMA
STEPS FORWARD MODULE

Addressing the Social Determinants of Health

https://edhub.ama-assn.org/steps-forward/module/2702762
What excites me about what I’ve heard?

Take a few minutes to talk together. Then, we’ll explore our ideas & plans as a group.
Can you see the intersections?

and

How will you leave in action?
THANK YOU!

Contact Information

Mary Reeves MD

Email: marysalida@gmail.com
Twitter: @MarySalida
What’s Coming Up Next for the NH Citizens Health Initiative
Educational Activities
## Project Overview

NH Citizens Health Initiative has partnered in the Northern New England Project ECHO® Network since 2016 and has assisted in activities around the development of several ECHOs across Northern New England.

New England Project ECHO® Network Upcoming Session:

Enhancing the Care of and Health of Older Adults Living With Dementia

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## Project Activities

### Perinatal SUD Continuum of Care
- Completed Fall 2018
- 21 Participant Sites; 62 Team Members; 10 Faculty

### Medications for Addiction Treatment
- Fall 2018 – Summer 2019
- 27 Participant Sites; 100 Provider team members; 11 Faculty

### Care for Older Adults
- Fall 2018 – Summer 2019

For more information please contact:

Marguerite Corvini
Marguerite.Corvini@unh.edu

## Partners:
- Maine Quality Counts
- NH Citizens Health Initiative/UNH IHPP
- Vermont Program for Quality in Health Care
- ME, NH, and VT AHECs

Funding from: Rural Health Network Development Program, HRSA. Contract D06RH31043.
Partnership for Academic-Clinical Telepractice: Advanced Nursing Education Workforce (PACT-ANEW)

**Project Overview**

- The UNH ANEW Program provides support for preceptors educating Family Nurse Practitioner (FNP) students in underserved areas.

- Tuition support for eligible FNP students

- Clinical education through Project ECHO community addressing high need healthcare topics

- Develop Community Telepractise sites funding available*

**Project Activities**

- Established relationship with community practices

- Developed learning modalities tools for high need areas (behavioral health and substance use disorders)

**Partners:**

- Southern New Hampshire Area Health Education Center
- University of New Hampshire, Department of Nursing

Funding from the Health Resources and Services Administration 1 T94HP328950100

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*For more information please contact:
Marcy Doyle
Marcy.Doyle@unh.edu
Partnership for Academic-Clinical Telepractice: Medications for Addiction Treatment (PACT-MAT)

Project Overview

• First ECHO® to integrate into a Nursing Curriculum
• Looking to increase number of medications for addiction treatment prescribers
• Expand education and learning for Medications for Addiction Treatment
• 18 practice sites

Project Activities

• Developed an all-teach-all learn community.
• Onboarded 30 post-masters and family nurse practitioner students
• Developed new partnerships in the community for learning

Currently recruiting for Cohort 2 starting Winter 2020

For more information please contact: unh.projectecho@unh.edu

Partners:
• University of New Hampshire, Department of Nursing

Funding from the Substance Abuse and Mental Health Services Administration 1H79TI081677
NH Mental Health Care Access in Pediatrics (NH MCAP)

**Project Overview**

- Focused on increasing capacity of pediatric providers to address behavioral health concerns
- Up to 15 practices recruited for each ECHO cohort (meeting monthly); 3 cohorts over 4 years
- ECHO participants have access to limited teleconsult service through ECHO experts
- State-wide pediatric behavioral health referral directory provided to participants

**Project Activities**

- Participants can be pediatric, family, or primary care practices in any area of the state
- Practices will join monthly 1.5-hour ECHO sessions for 10 months
- Practices will be asked to present one case study during the cohort

*Recruiting up to 15 practices to begin first ECHO cohort in Winter of 2020*

*For more info or to sign up contact: Devan Quinn*

[Devan.Quinn@unh.edu](mailto:Devan.Quinn@unh.edu)

**Partners:**

- NH Maternal and Child Health Bureau, NH DPHS, NH DHHS

Funding from the Health Resources and Services Administration
HRSA – 18 – 122
Quality Improvement Activities
Trauma-Informed Care
Quality Improvement Project

Project Overview
• Increase practice and provider knowledge about trauma-informed care

• Recruiting clinics in Manchester, Nashua, Coos County, Monadnock region

• 12 practices will receive a 1-hour training on trauma informed care (CME/CNE credit)

• 4 of those practices will then be eligible for 15 months of clinical facilitation and advanced trainings to plan and implement trauma-informed care in their practice

Project Activities
• Recruiting pediatric practices or health centers in targeted communities for 1 hour trainings

• Practices must have completed the 1-hr training to be eligible for the extended trauma-informed care implementation phase

Partners:
• Dartmouth-Hitchcock Trauma Intervention Research Center

Currently recruiting pediatric practices in targeted communities for trainings Fall 2019

For more info contact: Devan Quinn
Devan.Quinn@unh.edu

Funding from the New Hampshire Children’s Health Foundation

www.citizenshealthinitiative.org | 2 White Street Concord, NH 03301 | @CitizensHealth
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Strafford County Pediatric Screening Project (SCPS)

Project Overview
- Support up to 3 practices for 8 months in adoption of AAP standard for developmental screening
- Piloting Social Determinants of Health (SDOH) and Adverse Childhood Experiences (ACEs) screening
- Practices provided a referral resource sheet and patient registry to referral monitoring

Project Activities
- Recruiting pediatric practices - welcoming to practices outside Strafford County
- Project starting soon!

For more info contact:
Devan Quinn
Devan.Quinn@unh.edu

Funding from
Harvard Pilgrim HealthCare
ECHO® - AMPLIFI

**Project Overview**

- A partnership between Citizens Health Initiative and the Clinical Trial Network-Northeast Node for ECHO-Augmented MAT Practice Learning to Implement Facilitated Quality Improvement

- **Facts:**
  - Expand evidence-based quality improvement (QI) methods
  - Standardized data collections to:
    - improve fidelity to best practices,
    - promote optimal patient outcomes,
    - show growth,
    - target areas for improvement, and
  - give practices additional tools to sustain the learning provided in the ECHO.

**Project Activities**

- 5 practices involved
- Monthly on-site facilitation and technical assistance

**For more information please contact:**

Corina Chao
Corina.Chao@unh.edu

**Partners:**

- The National Drug Abuse Treatment Clinical Trials Network-Northeast Node

**Funding from National Institutes of Health, National Institute on Drug Abuse, Contract 3UG1DA040309-05S3 to Trustees of Dartmouth College.**
Chronic Care Quality Improvement (CCQI)

Project Overview

Collaborative learning and onsite support for the prevention and management of prediabetes, diabetes, hypertension, and elevated cholesterol through evidence-based quality improvement strategies and quarterly case-based learning via ECHO.

Project Activities

• 10 Steps to Improving Diabetes Care in New Hampshire: A Practical Guide for Clinicians and Community Partners

• Recruitment of 5 practice teams

• Conducting readiness assessments

• Kickoff In-Person Session: November 13, 2019

Partners:

Funding made possible by cooperative agreement NU58DP006515 between the New Hampshire Department of Health and Human Services, Division of Public Health Services and the Centers for Disease Control and Prevention.

If interested, please contact:
Corina Chao
Corina.Chao@unh.edu
Health Policy and Practice Analysis and Dissemination Project

Project Overview

To develop and support a forum to identify critical issues that need to be analyzed, analyzing data and policy to understand the implications of policy changes, dissemination of information to describe implications of policies, and vetting key issues with a robust network of stakeholders.

Project Activities

- BHI Learning Collaborative modules
- Research policy issues
- Material development to disseminate key messages

Beginning October 2019

For more information please contact:
Jo Porter
Jo.Porter@unh.edu

Partners:
A Cross-IHPP Project

Funding from
UVM Rural Center on Addiction: NH Partner

Project Overview
The NH Citizens Health Inititiave will serve as the NH partner for the Northern New England-wide UVM Rural Center for Addiction, working to bring evidence-based practice and expand treatment and prevention for patients in rural-designated counties in VT, NH, and ME.

The Center will identify needs of rural communities in VT, NH, and ME and disseminate evidence-based methods to effectively address the OUD epidemic and support expansion of OUD treatment capacity in rural communities using science-based knowledge and methods.

Project Activities
- Education and resources on evidence-based treatment and prevention.
- Technical Assistance and workforce training and training on evidence-based practices for assessing and treating rural patients’ SUDs and related needs.
- Support expansion of OUD treatment capacity in rural communities using science-based knowledge and methods.

Working with Practices in Rural NH Counties
Beginning Soon
For more information please contact: Jeanne Ryer
Jeanne.Ryer@unh.edu

Partners:
- University of Vermont
- Cutler Institute, Muskie School of Public Service

Funding from:
Regional Centers of Excellence in Substance Use Disorder Education Program: Rural Centers of Excellence, HRSA
And Stay Tuned...
Practice Transformation Network 2.0?

Clinician Quality Improvement Contactors (CQIC)

CMS will announce successful bidders in November 2019
CLOSING REMARKS:
JEANNE RYER, MSc, EdD

Director
NH Citizens Health Initiative
Institute for Health Policy and Practice
University of New Hampshire
SYMPOSIUM FEEDBACK

We would love to hear your feedback about our Symposium!

Please complete the evaluation attached to the agenda.