



U.S. Department of Health and Human Services



Agency for Healthcare Research and Quality

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# Best Practices for Measuring Practice Transformation to Implement the Triple Aim

## **Presented By:**

Chet Fox, MD, FAAFP, FNKP; Lynne Nemeth, PhD, RN, FAAN; Zsolt Nagykaldi, PhD;  
Paula Darby Lipman, PhD; Rodger Kessler, PhD, ABPP

## **Moderated By:**

Rebecca Roper, MS, MPH, Director, Practice-Based Research Network Initiative,  
Agency for Healthcare Research and Quality

Sponsored by the AHRQ PBRN Resource Center

November 19, 2014



# Agenda

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- Welcome and introductions
- Presentations
- Q&A session with all presenters
- Instructions for obtaining CME credits

**Note:** After today's webinar, a copy of the slides will be e-mailed to all webinar participants.



# Disclosures

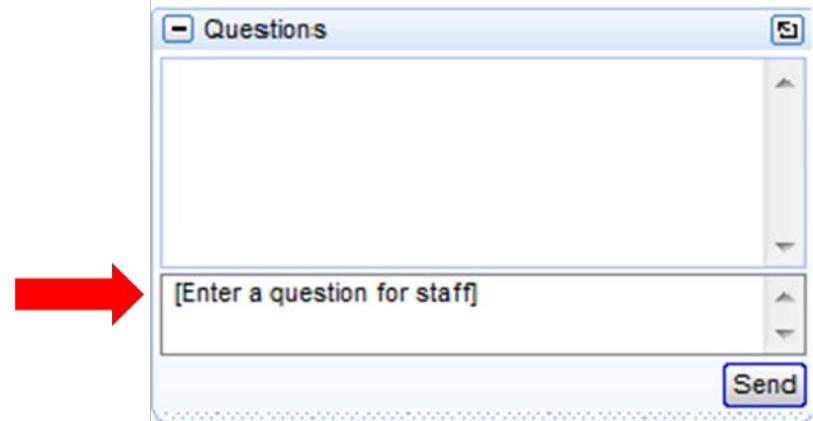
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- None of today's presenters have financial relationships to disclose.
- Presenters will not discuss off label use and/or investigational use of medications in their presentations.



# How to Submit a Question

- At any time during the presentation, type your question into the “Questions” section of your GoToWebinar control panel.
- Select “Send” to submit your question to the moderator.
- Questions will be read aloud by the moderator.





# Today's Presenters

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## TRANSLATE: Framework for Evaluating Practice Transformation



**Chet Fox, MD, FAAFP, FNKP**  
Professor, University at Buffalo;

Director, Upstate New York Practice-based Research Network (UNYNET);

Research Director, AHRQ P30 Network of Networks  
Center of Excellence Grant



# Today's Presenters

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## Measuring Practice Transformation



**Lynne Nemeth, PhD, RN, FAAN**

Professor, College of Nursing, Medical University of  
South Carolina;

Investigator, Primary (Care) Practices  
Research Network (PPRNet)



# Today's Presenters

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## Achieving and Measuring Practice Change: The Solberg-Mold Practice Change/QI Model



**Zsolt J. Nagykaldi, PhD**

Associate Professor and Director of Research,  
Department of Family and Preventive  
Medicine,  
University of Oklahoma Health Sciences  
Center;

Research Director, Oklahoma Physicians  
Resource/Research Network (OKPRN)



**Paula Darby Lipman, PhD**

Senior Study Director, Westat



# Today's Presenters

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## The Errors of our Ways: From behavioral co-location carve-out to transformed integration of care



**Rodger Kessler, PhD, ABPP**

Fellow, Health Economics Unit and Assistant Professor of Family Medicine,  
University of Vermont College of Medicine;

Director, Collaborative Care Research Network, National Research Network  
Senior Scientist, American Academy of Family Physicians;

Clinical Associate Professor, Doctor of Behavioral Health Program, Arizona  
State University Doctoral Program



## Polling Question:

Check which describes your experience with measuring/evaluating practice transformation (PT):

# TRANSLATE

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Framework for Evaluating Practice Transformation

Chet Fox MD

University at Buffalo

# History

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- Late 1990's Kevin Peterson wanted to improve DM care in PCP offices
- Did literature search on modalities that would be effective
- He found nine that were put into the acronym TRANSLATE
- Did successful randomized control trial in over 8,000 diabetic patients
- It was modified and adapted for a 40 practice NIH R-01 pragmatic clinical trial comparing Computer Decision support to facilitated support
- TRANSLATE Rubric was developed for evaluation

# TRANSLATE

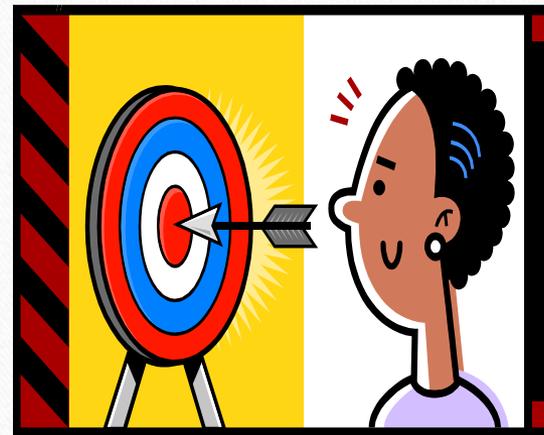
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- **T**arget
- **R**eminder
- **A**dministrative Buy-In
- **N**etwork Information System
- **S**ite Coordinator
- **L**ocal Clinician Champion
- **A**udit and Feedback
- **T**eam Approach
- **E**ducation

# Target

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- Goal setting
- Needs to be
  - Clear Measurable and feasible
- Common office problems
  - No targets
  - Trying to do too many things at once



# Reminder

- Actionable information at the point of care

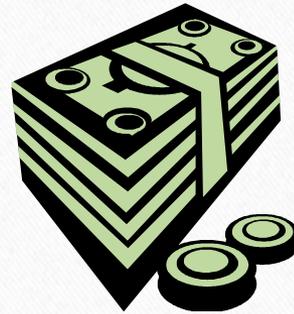
The screenshot shows a medical software interface with a reminder list for patient Mary A. Simmons. The list is organized into sections: 'Due/Alert', 'Approaching Due', and 'Not Due'. The 'Approaching Due' section is highlighted in orange and includes a 'Pap Smear' due on 06/30/00. The 'Due/Alert' section is highlighted in red and includes various medical alerts, such as 'Atrial Fibrillation w/Coumadin - PT/INR' and 'HDL < 35' (with a value of 49 and a red bar). The interface also shows a 'MEDENT Sidebar' on the right and a '\* formula has a provider override' message at the bottom.

Due/Alert	Last Date	Result	Next Date ...
Atrial Fibrillation w/Coumadin - PT/INR	Unknown		
Diabetes - Foot Exam	Unknown		
Diabetes - Microalbumin	Unknown		
Diabetes - Retinal Exam	Unknown		
Diabetes: Fluvax	Unknown		
Fluvax: High Risk	Unknown		
HDL < 35	03/10/00	49	
Hyperlipid - Lipid Panel	Unknown		
Imm Fluvax	Unknown		
Imm Pneumococcal	Unknown		
Imm Tetanus	Unknown		
Imm Zostavax	Unknown		
Incontinence Assessed	Unknown		
PT/INR	Unknown		
<b>Approaching Due</b>	<b>Last Date</b>	<b>Result</b>	<b>Next Date...</b>
Pap Smear	06/30/99		06/30/00
<b>Not Due</b>	<b>Last Date</b>	<b>Result</b>	<b>Next Date...</b>

# Administrative Buy-in

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- Commitment of Resources
  - Money
  - Personnel



# Networked Information Systems

- Population Health
  - Registries
  - Preferably easily created

The screenshot shows a web-based interface for managing a patient registry. At the top, there are navigation links for 'By Provider' and 'My Panel'. Below this is a 'Filtering Options' section with various checkboxes and dropdown menus for filtering patients based on medical history (e.g., HbA1c, BP, LDL) and demographics (e.g., Sex, Age). A red circle '1' highlights the HbA1c filter. Below the filtering options is an 'Export Options' section with a dropdown menu for 'Export' (4) and a 'Get Data' button. The main content area is titled 'Patients with Diabetes' and shows a table of patient data (3). The table has columns for Patient Name, Sex, Age, Last HbA1c Value, Last HbA1c Date, Last BP Date, Last Blood Pressure Reading, Avg of the Last Three BP Readings Within 12 Months (2), Last LDL Value, Last LDL Date, Date of the Last Lipid Foot Exam, Date of the Last Lipid West Rx, Last AST ALT Date, Last Primary Care Visit, Next Primary Care Visit, # of Primary Care Visits within the last 12m, Last Visit with PCP, Next Visit with PCP, and Saw PCP in the last 12m. A red circle '3' highlights the first row of the table. Below the table, there is a 'Provider: 110061 - Cefirst Colast' and 'Roster Total as Selected: 5'. A 'Click Sort by Multiple Columns:' link is also present. A red circle '4' highlights the 'Export' dropdown menu.

**SQL has several built-in registries that allow for management of the following:**

- Diabetes
- Congestive Heart Failure
- Atrial Fibrillation
- Hypertension
- Cardiovascular Disease
- Asthma
- Depression
- Obesity
- Medication Adherence
- And others...

**The registries are designed to meet the specific needs of the customers.**

# Site Coordinator

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- Local accountability
- Person responsible for making sure the work is done.
- Any number of people can take this role
  - The doctor in a small practice
  - The office manager
  - Head Nurse etc.



# Local Clinician Champion

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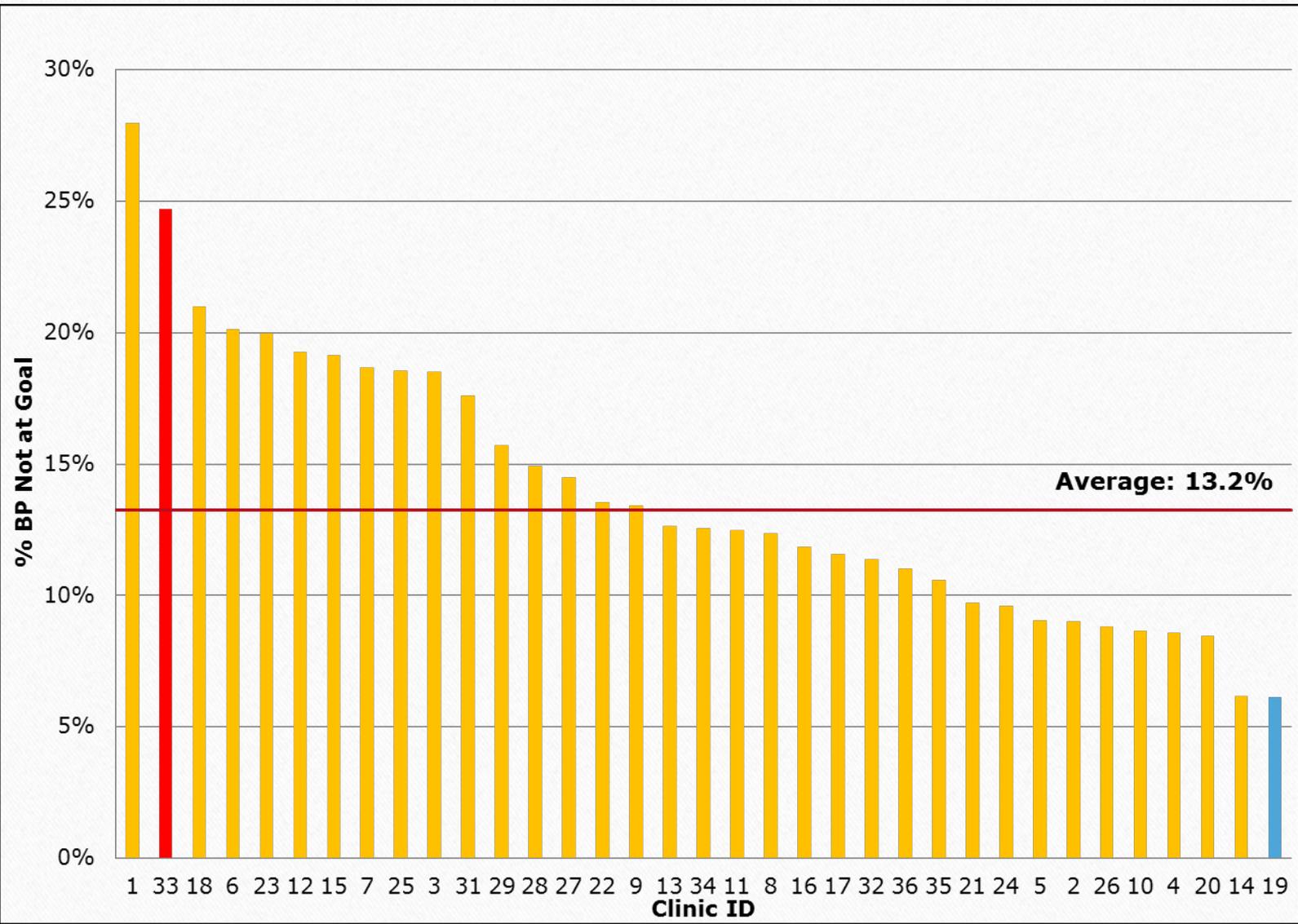
- For Clinician buy-in
  - Explanation of Evidence Base
- Does not have to be MD (but usually is)
  - NPs and PAs have done a good job with this
    - Large regional variation
    - Some only accept MD



# Audit and Feedback

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- Longitudinal Reports
  - How the practice is progressing over time
- Benchmarking Reports
  - How the practice is doing compared to others



# Team Approach

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- Based on other successful work such as:
  - Toyota Quality Circles
  - Patient safety in the Airline industry.
- Huddles (brief micro-team meetings) have also shown success



# Education

- Training in all its forms:
  - Academic Detailing\*
  - Collaborative Learning Groups\*
  - In-service
  - CME etc.

\* Most commonly used in practice transformation

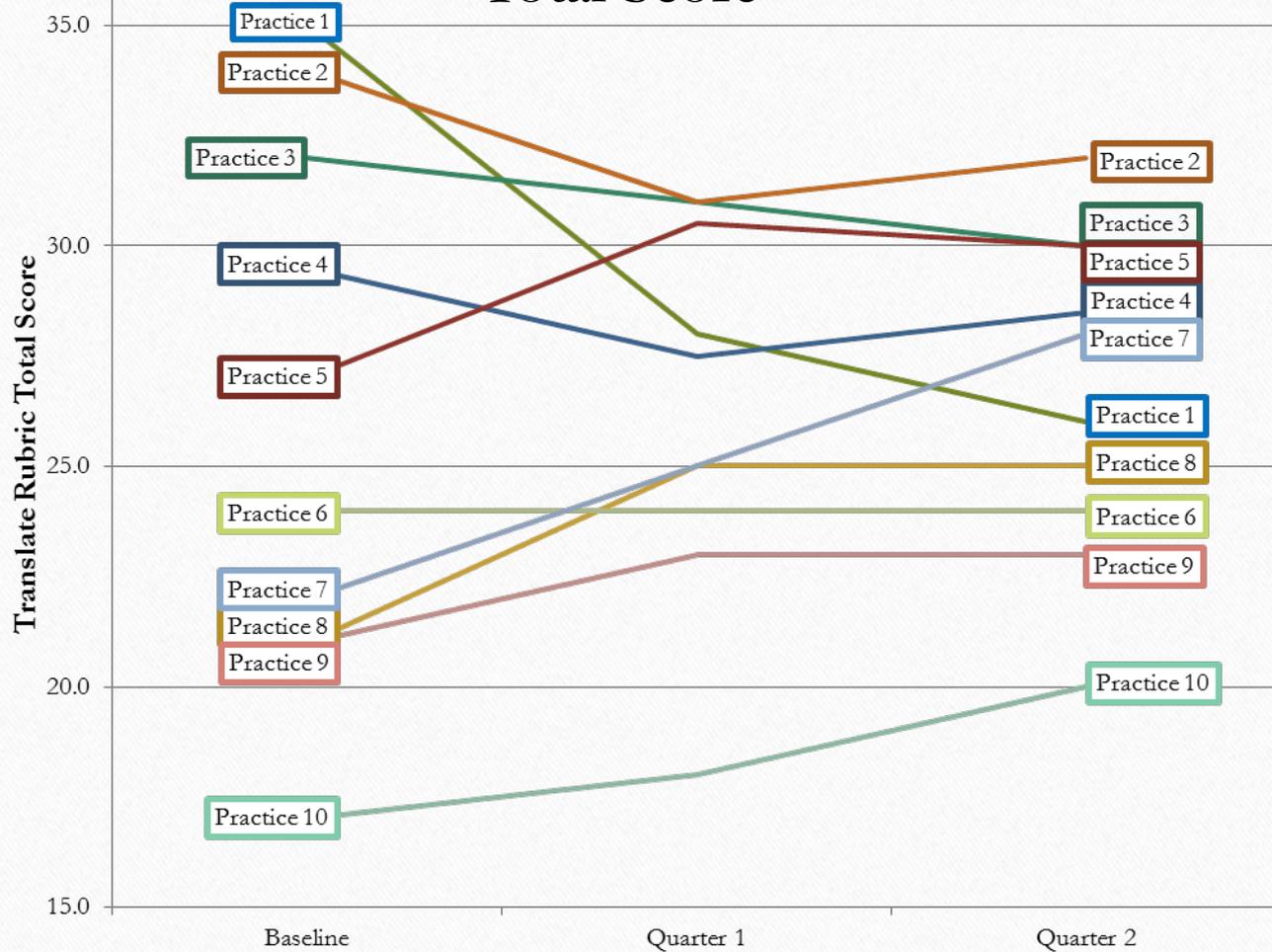


# TRANSLATE Scoring Rubric

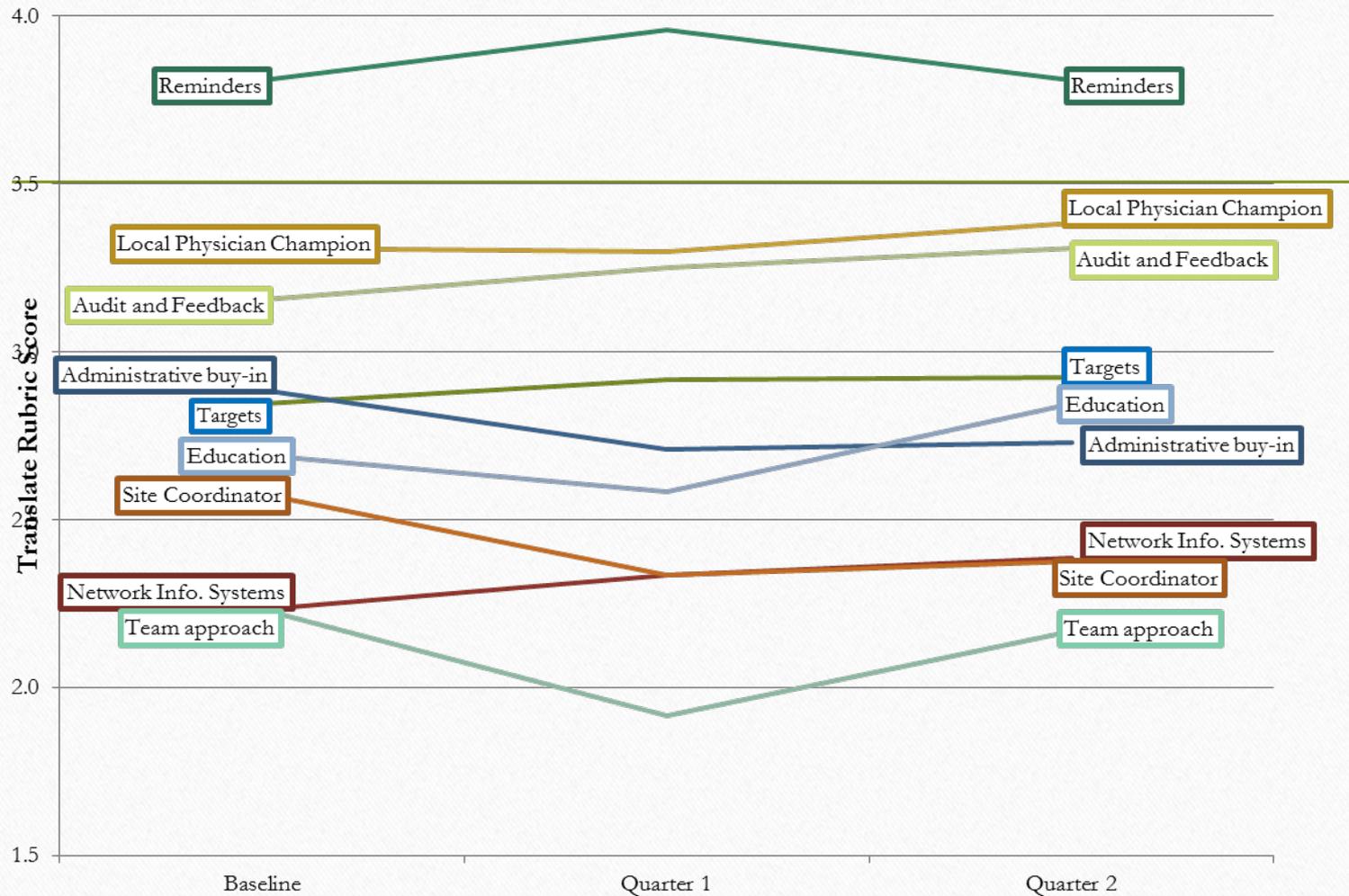
Translate element	1	2	3	4	Score
Targets	No targets set	Vague or non-measurable targets	Clear, measurable, but not feasible targets	Clear, measurable and feasible targets	
Reminders	No Reminders available	Reminders available but never used	Reminders available but used infrequently	Reminders routinely used	
Administrative buy-in (Resource allocation)	Leaders resistant	Leaders agreeable but unwilling to commit resources (cool)	Leaders agreeable and willing to commit limited resources (lukewarm)	Leader willing to commit all resources necessary (enthusiastic)	
Network Information Systems (Registries)	No information system or unable to create registries	Able to create registries but none created	Few registries created or used < 3 conditions	Registries created and used for at least 3 conditions	
Site Coordinator	No site coordinator identified	Site coordinator identified but has no time for QI activities	Site coordinator has limited time to do QI	Site coordinator with clear mission, resources, and personnel to complete QI work	
Local Physician Champion	Not identified	Identified but uninvolved (name only)	Lukewarm support	Enthusiastic support	
Audit and Feedback	Never done	Reports available but not disseminated	Reports disseminated occasionally and only at the practice level	Individual reports disseminated at least 2 times per year	
Team approach	No teams formed	Limited teams that function from a top down approach	Limited teams that get input from just a few individuals	Non-hierarchical broadly based teams	
Education - CME, collaborative learning groups, staff training	No opportunities for education	Rare educational opportunities	Occasional educational opportunities	Frequent educational opportunities	
Total score for all elements at benchmark					0.0

# Preliminary Results

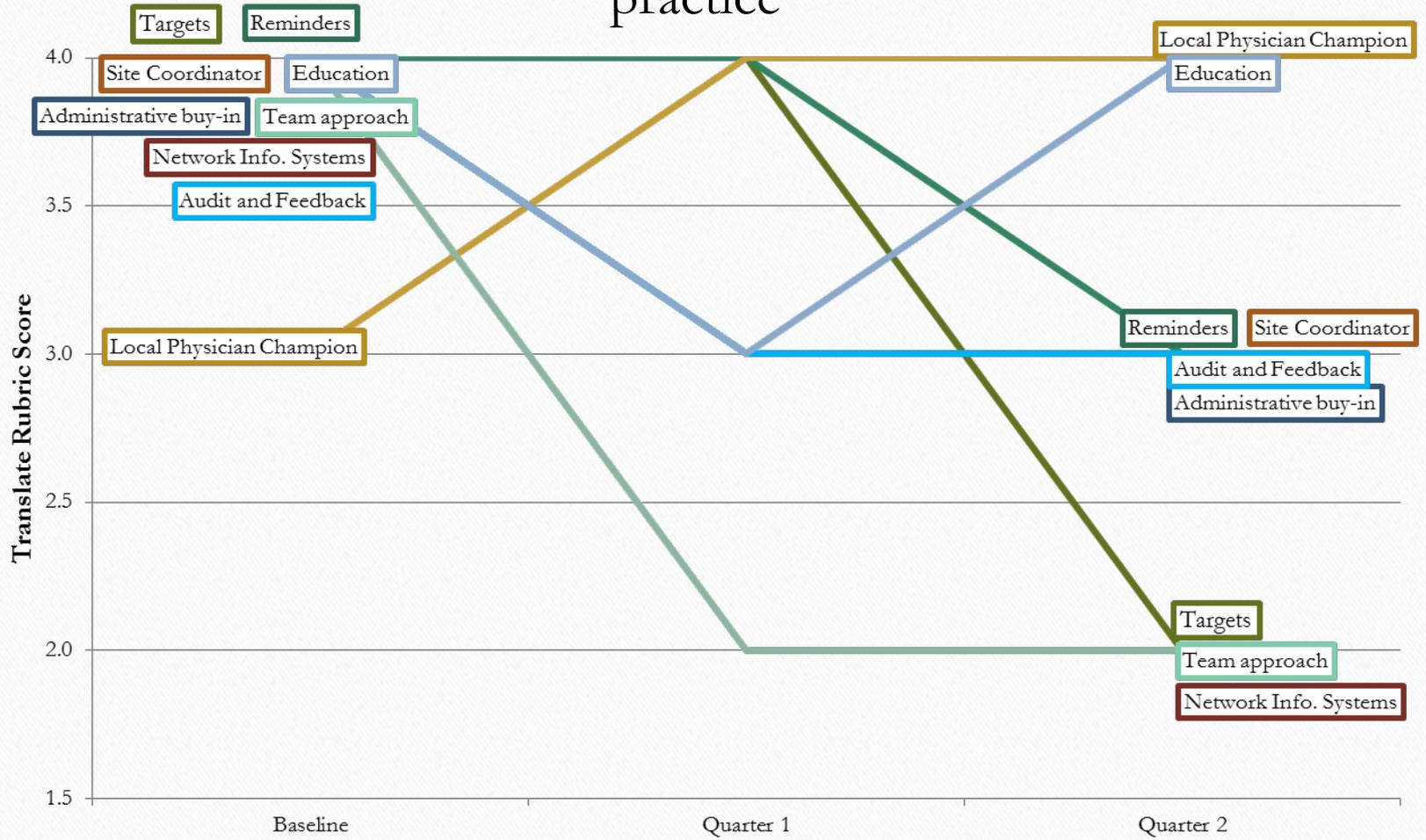
## Total Score



## Change by Individual element (all practices)



# Individual elements for individual practice





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## Polling Question:

Have you had experience using an implementation survey to identify areas on which to focus transformation efforts?



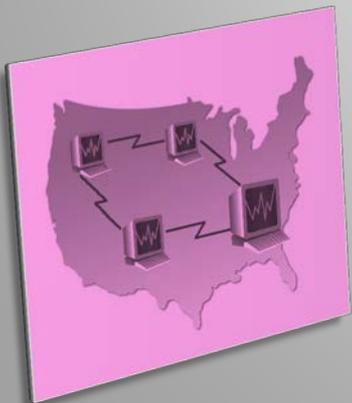
# MEASURING PRACTICE TRANSFORMATION

Lynne S. Nemeth, PhD, RN, FAAN

Professor: College of Nursing

Investigator: PPRNet

Medical University of South Carolina



# ACKNOWLEDGEMENTS

- ◉ Steven M. Ornstein, MD
- ◉ Andrea M. Wessell, PharmD
- ◉ Cara B. Litvin, MD, MS
- ◉ Ruth G. Jenkins, PhD
- ◉ Paul J. Nietert, PhD
- ◉ PPRNet Member Practices

R03HS018830 and R18HS022701

Agency for Healthcare Research and Quality  
(AHRQ)

# OBJECTIVES

- ◉ Disseminate a conceptual model for improving primary care using health information technology (IPC-HIT)
- ◉ Discuss model concepts and practice activities
- ◉ Explain how these concepts were used to develop a survey measuring “meaningful use”
- ◉ Consider implications of measuring these activities for their correlation with clinical quality measures (CQM)

# SYNTHESIZING LESSONS LEARNED

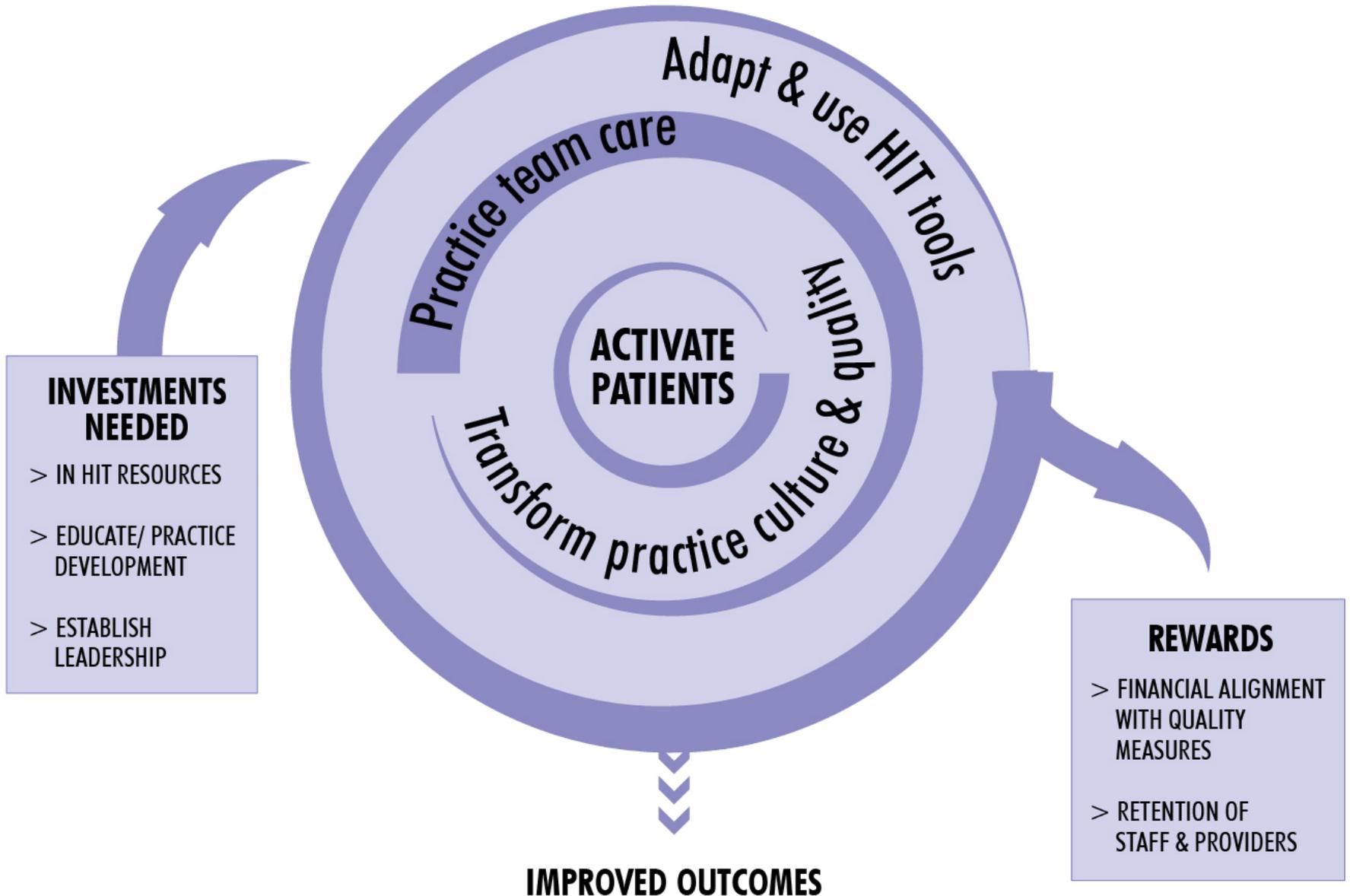
- ◉ Secondary analysis of seven PPRNet studies qualitative data (2001-2012)
  - Cardiovascular/stroke prevention, alcohol screening and brief intervention, broad primary care measures, colorectal cancer screening, medication safety, standing orders
- ◉ 134 practices nationwide participated in this collaborative learning community

## Findings

- ◉ Practices use HIT/staff in new ways
- ◉ Complex interventions rely on four main concepts

# IMPROVING PRIMARY CARE USING HEALTH INFORMATION TECHNOLOGY (HIT)

PPRNet - TRIP - QI



QUALITY MEASURES: PPRNet, NCQA, CMS

# Concepts and Strategies: Complex Interventions

		Specific Approaches by Study		
		TRIP-II to ATRIP (2001-2006)	AA/AM/SO/C-TRIP (2005-present)	MS-TRIP (2007-present)
<b>Concepts</b>	<b>Practice Team Care</b>	<ul style="list-style-type: none"> <li>• “Involve all staff”, new roles/responsibilities</li> <li>• Clinicians agree to decrease practice variation</li> </ul>	<ul style="list-style-type: none"> <li>• Structured screening tools (MAs/nurses)</li> <li>• Complementary team roles better defined, providers closing loop</li> </ul>	<ul style="list-style-type: none"> <li>• Medication reconciliation, outreach as needed</li> </ul>
	<b>Adapt and Use HIT Tools</b>	<ul style="list-style-type: none"> <li>• Staff increased use of EHR</li> </ul>	<ul style="list-style-type: none"> <li>• Specific templates used for decision support</li> <li>• Revised/edited, add macros, applied age, gender, Dx/ Rx templates</li> <li>• Lab interfaces, scanning, eRX, web-based patient portals added</li> </ul>	<ul style="list-style-type: none"> <li>• Rx/Dx templates applied, improved medication reconciliation, increased attention to dosing alerts</li> </ul>
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**• “Involve all staff”, new roles/responsibilities**  
**• Clinicians agree to decrease practice variation**

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• Staff increased use of EHR

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# NEED: MEASUREMENT TOOL

- Meaningful Use Study provided opportunity
- Proposed Meaningful Use Stage 3 CQM
  - 21 measures selected relevant to primary care
  - *Measures: Population/Public Health, Clinical Process/Effectiveness and Patient Safety and Efficient Use of Healthcare Resources*
- Survey developed using five iterative rounds to examine practices substantial engagement or “meaningful use” of their EHR
- Each item mapped to the CQM domain, IPC-HIT concept and CFIR domain

# EXEMPLARS OF MEANINGFUL USE SURVEY

## ◎ IPC-HIT concepts

- Practice Team Care
- Adapt and Use HIT tools
- Transform Practice Culture and Quality
- Activate Patients

## ◎ CFIR domains

- *Intervention Characteristics*
- *Outer Setting*
- *Inner Setting*
- *Characteristics of Individuals*
- *Process of Implementation*

# KEY QUESTIONS

- ◉ Do you agree with the following CQM?
- ◉ What proportion of your practice's clinical staff members are educated on specific clinical quality goals for the following?
- ◉ Are practice clinical staff authorized by standing order protocols to order or perform the following?
- ◉ To what extent does your practice use EHR reminders (flags, health maintenance, or note templates with prompts, etc), as decision-support to help meet the following clinical quality goals
- ◉ To what extent does your practice use EHR tools (embedded web links, templates, letters) for patient education that reinforce the selected population management/public health goals?

# ASSOCIATIONS

Survey Category	CQMs Associated (Multivariate Analyses)
Provider Agreement	CRC Screening
Staff Education	Breast ca screen, DM nephropathy screen, IVD ASA, Depression screen
CDS (HER Reminders)	Breast, Cervical, & CRC ca screen DM nephropathy screen HF: ACE/ARB & BB Chlamydia, Depression screen Flu pneum vaccines
Standing Orders	(Many in bivariate analyses, none when controlling for DCS use)
HER Patient Educ	Cervical ca screen, HGA1C control, HF: BB

# FUTURE RESEARCH IS NEEDED

- ◉ Exemplars of Meaningful Use Survey needs further testing to be able to more widely measure transformation
- ◉ A quantitative measure can be used to further test associations of practice strategies with CQM performance
- ◉ There is an important need to understand how practices can make improvement— measurement of these core strategies may signal specific areas that can be used to address the goals.

QUESTIONS:

[nemethl@musc.edu](mailto:nemethl@musc.edu)



# Achieving and Measuring Practice Change: The Solberg-Mold Practice Change/QI Model

Co-presenters:

Zsolt Nagykaldi, PhD (University of Oklahoma Health Sciences Center & OKPRN)

Paula Darby Lipman, PhD (Westat)

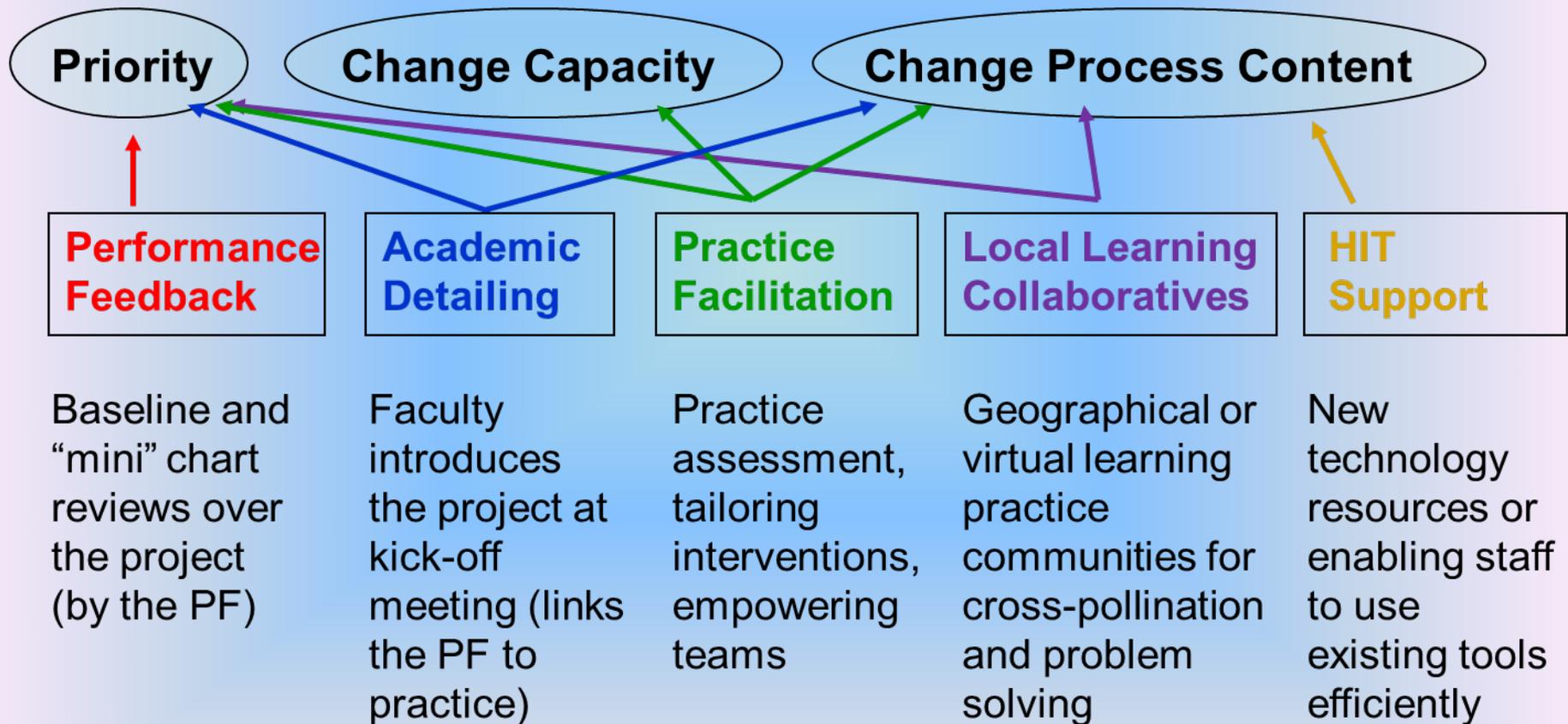
# Acknowledgements

- James W. Mold, MD, MPH (PI, OKPRN)
- Cheryl B. Aspy, PhD (OKPRN)
  
- Paul D. Smith, MD (WREN)
- Therese Zink, MD (formerly at MAFPRN)
- Lyndee Knox, PhD (LANet)
- Paula Darby Lipman, PhD (Westat)
  
- Chet Fox, MD (UNYNet)
- Leif I. Solberg, MD (HealthPartners)

Supported by AHRQ grant (1R18HS019945): Leveraging practice-based research networks to accelerate implementation and diffusion of chronic kidney disease guidelines in primary care practices

# The Solberg-Mold Practice Change/QI Model

## Proposed effects of the QI Interventions on Change Elements



# The Solberg-Mold Practice Change/QI Model

## Example: The CKD Project Funded by AHRQ (2010-2013)

- Multi-PBRN R18 to implement and disseminate CKD clinical guidelines in primary care practices (multi-comp.)
- Academic detailing on CKD management best practices
- Regular performance feedback on reaching practice goals
- Facilitation of CKD guideline implementation (workflow redesign, tailoring, sharing solutions, empowering staff)
- Technical support for new features in EHR (e.g., eGFR)
- First wave (32) of practices accelerates diffusion to other practices (64) using LLCs

# Measuring Change Process Capability

- The Change Process Capability Questionnaire (CPCQ)
  - <http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod6appendix.html>
- Developed to measure an organization's ability to maintain change
  - 30 factors and strategies ranked most important for successful implementation by experienced quality improvement leaders
- Relationship between survey scores and depression improvement among 41 medical groups
- Solberg, Asche, Margolis, Whitebird - Am J Med Qual 2008

# Measuring Change Process Capability

## Priority - visual analog scale

- “Considering all the priorities your clinic has over the next year (e.g., EHR, financial goals, QI of various conditions, physician recruitment), what is the priority for your clinic to improve [target] care (on a scale of 0-10, where 0 = not a priority, 5 = medium priority, and 10 = highest priority of all)?”

## Organizational factors

- Previous history of change
- Plans for organizational refinement
- Ability to initiate and sustain change

**Strategies:** specific approaches to managing change or to adoption of improved [targeted] care (e.g., periodic measurement of performance or delegating physician work to non-physician staff)

- Yes (worked well, did not work well)/No

# Findings: Change in Practice Performance (Aim 1)

**Aim 1:** Determine whether “early adopter” practices (Wave I) could recruit additional practices (Wave II) to implement CKD guidelines and facilitate the implementation process in these second-wave practices

- Following the intervention, Wave I practices increased use of ACEIs/ARBs, discontinuation of NSAIDs, testing for anemia, and testing and/or treatment for vitamin D deficiency.
- Most were able to recruit two additional practices for Wave II
- Wave II practices also increased their use of ACEIs/ARBs and testing and/or treatment of vitamin D deficiency.

# Findings: Practice Process Change (Aim 2)

**Aim 2:** Determine whether the change processes used by Wave II practices would be the same as or different from those used by the early adopters

- Differences between measures of priority, change capacity, and care processes between baseline and post-intervention were estimated using the paired t-test.
- For all practices:
  - Priority for improving care of patients with CKD remained relatively high (no significant pre-post change)
  - No significant change in subscales designed to measure organizational factors associated with practice change capacity (i.e., history of change, continuous refinement and sustaining change)
- Number of change strategies increased for Wave I practices only
  - However baseline scores were higher in Wave II practices.

# Conclusions

- The CKD project was able to increase the number of implemented strategies for practice improvement as delineated by the Solberg-Mold QI model.
- It is feasible to effectively operationalize the Solberg-Mold practice change model in quality improvement projects in primary care practices.
- Diffusion, generally considered to be a passive process, can be facilitated by PBRN researchers and member practices using a combination of assistance and incentives.
- Wave II practices showed improvements in care of CKD patients similar to Wave I practices but with less PF assistance.
- PBRNs are well-positioned to replicate this process for other evidence-based innovations.

In press:

Mold et al. Leveraging practice-based research networks to accelerate implementation and diffusion of chronic kidney disease guidelines in primary care practices: A prospective cohort study. *Implementation Science*.

# The Errors of our Ways:

From behavioral co-location carve-out to transformed integration of care

Rodger Kessler Ph.D. ABPP

Fellow, Health Economics Unit

Assistant Professor of Family Medicine University of Vermont College of Medicine

Director, Collaborative Care Research Network, National Research Network Senior Scientist,  
American Academy of Family Physicians

Clinical Associate Professor, Doctor of Behavioral Health Program Arizona State University  
Doctoral Program

AAFP national research  
— network —



# Critical Issues in Behavioral Integration

## Same issues as those driving Primary Care Transformation

- Measurement
  - Patient Based
  - Practice Based
- Panel Based Focus on Complexity
- Transparent Bi-directional EHR with minimal text and extractable data fields used to impact care
- Implementation Science Driven Evidence Based Care

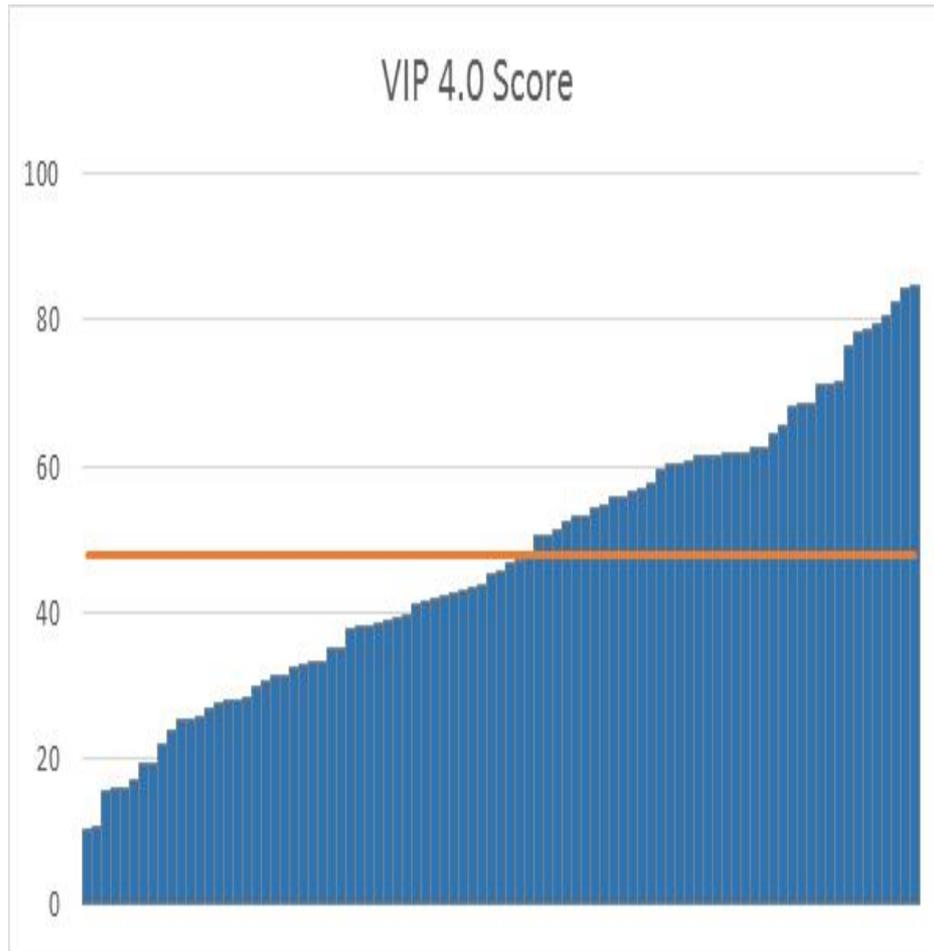
# Most Co-Located Care is not Integrated into Medical Practice

- 40% of practices have a behavioral health clinician, almost 50% case managers meager substance abuse clinicians
- Referrals, referral tracking, scheduling, information sharing less well integrated than other medical subspecialties
- Behavioral protocols: obesity 59%, insomnia 38% and headaches 34%.

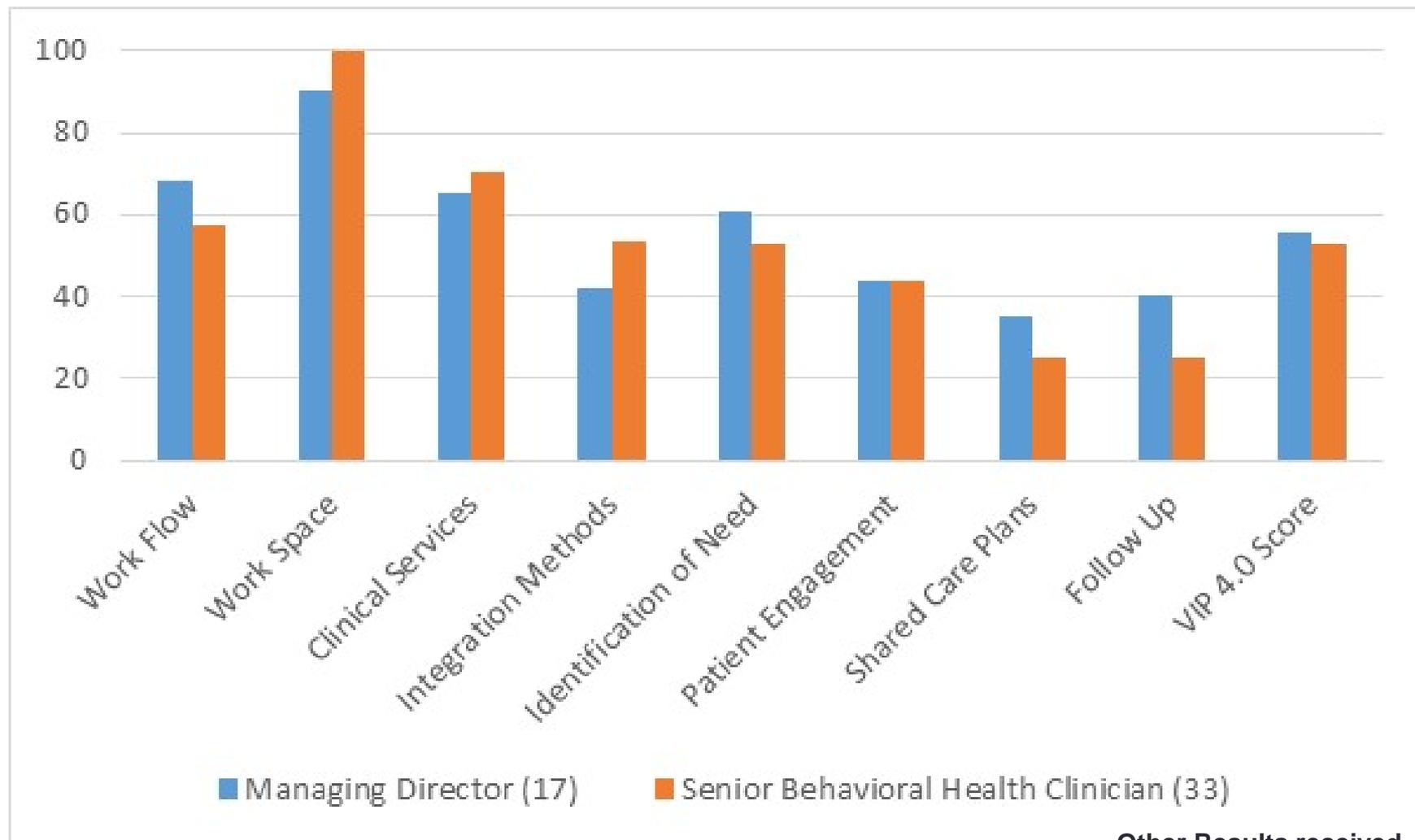
*Kessler, Miller, Kelly, Graham and Kennedy et.al, JABFM 2014*

# All Respondents (95)

Vermont Integration Profile 4.0  
(VIP) updated 5 Nov 2014



# Median scores from Managing Directors and Behavioral Health Clinicians



## Other Results received

- 3 - Practice Manager
- 3 - Managing Physician
- 0 - Student Intern

# The components of value added Behavioral Intervention in the PCMH

- Combine medical and behavioral benefits into one payment pool
- Target complex patients for priority behavioral health care
- Use proactive onsite behavioral "teams"
- Match behavioral professional expertise to the need for treatment escalation inherent in stepped care
- Define, measure, and systematically pursue desired outcomes
- Apply evidence-based behavioral treatments
- Use cross-disciplinary care managers in assisting the most complicated and vulnerable.

Kathol DeGruy and Rollman 2014 AFM

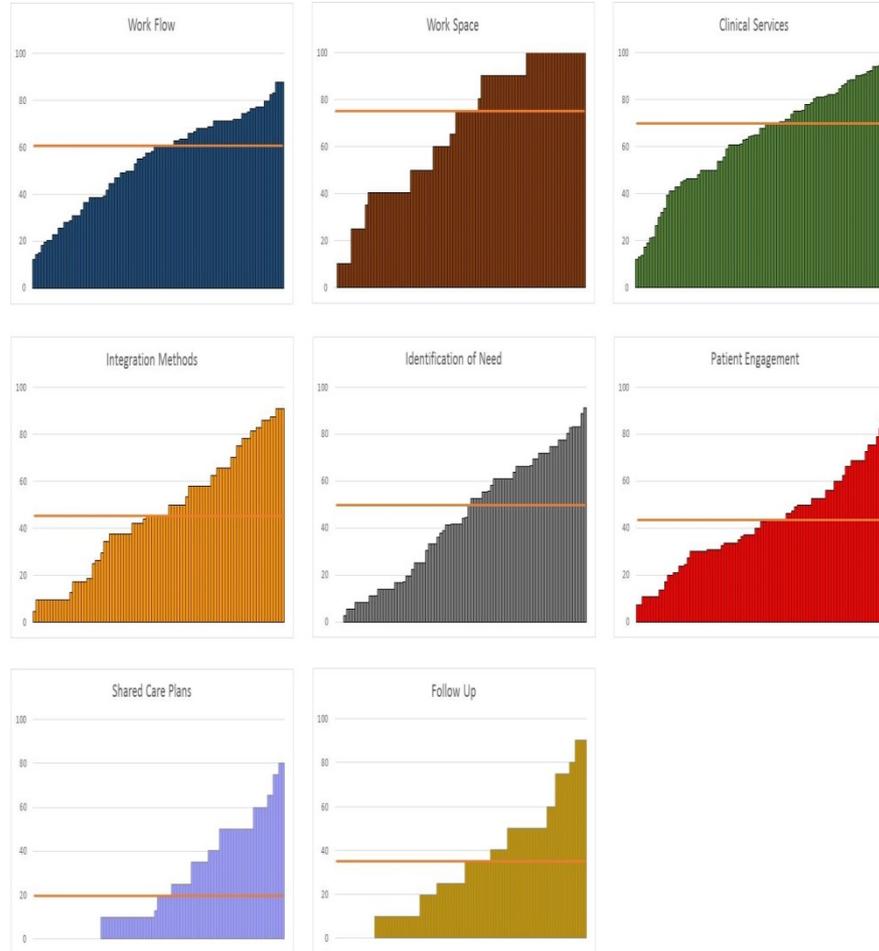
# Integration must involve measurement

- The Vermont Integration Profile
  - measures clauses of Peek's Lexicon

Workflow	Workspace	Clinical Services
Model Identification		Patient engagement
Shared care plans		Follow up

# All Respondents (95)

Vermont Integration Profile 4.0 (VIP) updated 5Nov2014



The VIP has 8 domains from 0 (absent) to 100 (continuously present).

Within each domain, each bar represents a practice and line (orange) represents median value of responses

# An in process panel based example

- NIMH grant number Practice level Diabetes Intervention using PRO's and EHR data to plan and deliver care
- Patient behavioral risk data become registry functions to assist in identification of cohorts
- Out of office patient reported data collection including patient assessment of willingness to work on an identified risk
- Team based care

# EHR Clinical and Quality Improvement Compatibility

- Templated drop down populated clinical assessment and notes
- Bi directional access communication
- Same scheduling and rescheduling process
- Retrievable elements and easily accessed reports
- Clinical and claims data able to associate

# Implementation Science Driven Evidence Supported Care

- Most behavioral care delivered is not evidence supported even when there is evidence based care available
- There is little relationship between emerging primary care integration developers and the Behavioral Medicine and Health Psychology research base
- Systematic PROCESS improvement focus to primary care behavioral integration is rare, despite evidence supported toolkits and resources

# Conclusions

- Behavioral transformation rarely receives the attention that primary care transformation receives but must be held to same standard
- Until the population health measurement, informatics and systematic process improvement include a strong focus of transformation of behavioral care-
- Primary care is left with behavioral health co-location not transformation
- It is no longer a technological issue or research limitation, it is a primary care leadership and investigator issue



VERMONT  
INTEGRATION  
PROFILE

*Rodger Kessler Ph.D. ABPP*

*Mark Kelly*

*Jon van Luling*

*Andrea Auxier Ph.D*

*Daniel Mullin Ph.D.*

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***Thank You!***

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**UNIVERSITY**  
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**COLLEGE OF MEDICINE**

<https://redcap.uvm.edu/redcap/surveys/?s=vEpGbwyFE6>



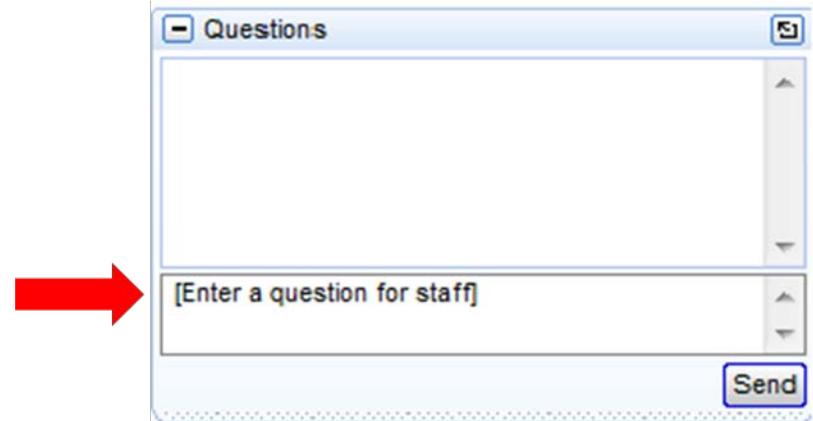
## Polling Question:

Is integration of evidence-supported behavioral interventions an important element of PC transformation?



# How to Submit a Question

- At any time during the presentation, type your question into the “Questions” section of your GoToWebinar control panel.
- Select “Send” to submit your question to the moderator.
- Questions will be read aloud by the moderator.





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## Polling Question:

I rely on AHRQ PBRN Resource Center Webinars to address PBRN needs not otherwise met:



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## Polling Question:

How frequently do you apply learnings from AHRQ PBRN Resource Center Webinars to PBRN-related work?



**Polling Question:**  
AHRQ PBRN Resource Center Webinars facilitate  
collaboration among interested parties:



# Obtaining CME Credit

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# Additional Practice Facilitation Resources

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- AHRQ PBRN Resource Center Webinars
  - *PBRN Workforce of the Future*: <http://pbrn.ahrq.gov/events/pbrn-workforce-future>
  - *AHRQ's Practice Facilitation Handbook: A Resource for New Facilitators and Their Trainers*: <http://pbrn.ahrq.gov/events/ahrq%E2%80%99s-practice-facilitation-handbook-resource-new-facilitators-and-their-trainers-0>
- AHRQ's Patient-Centered Medical Home (PCMH) Practice Facilitation Page
  - <http://pcmh.ahrq.gov/page/practice-facilitation>
- AHRQ's Primary Care Practice Facilitation Forum (PCPF) Newsletter
  - To subscribe, send an email to [PracticeFacilitation@mathematica-mpr.com](mailto:PracticeFacilitation@mathematica-mpr.com) and include "subscribe" in the subject heading



# Upcoming Events

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Upcoming AHRQ PBRN Resource Center Webinar:

- **December 11, 1:30 – 3:00pm ET: PRECIS Tool: Understanding your Research Intentions, the Pragmatic-Explanatory Continuum**

Visit <http://pbrn.ahrq.gov/events> for webinar registration information and details on other upcoming PBRN-relevant events

**If you have a suggestion for a webinar topic or would like to be a webinar presenter, send your feedback to: [PBRN@abtassoc.com](mailto:PBRN@abtassoc.com)**



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**Thank you for attending today’s PBRN webinar!**