

## A. COVER PAGE

**1. Title:** Disparities in Pneumococcal Immunizations among People with High-Risk Co-Morbid Conditions in a Patient-Centered Medical Home. **Grant ID #: 13146911** **Main Collaborators:** Partnership Health Center (PHC) and the Family Medicine Residency of Western Montana (FMRWM)

### **2. Abstract:**

The PHC/FMRWM proposed project will enable us to develop a sustainable process to mitigate the immunization disparity that currently exists among our patient population between some high risk groups for pneumococcal pneumonia and our proposed target population: tobacco users. **59.6%** of our 18 to 64 year olds with **diabetes** had received a pneumococcal vaccine, and **95.3%** of patients with **HIV/AIDS** were up to date on their pneumococcal vaccines. However among 3,790 current tobacco users only 31 (**0.8%**) had documented pneumococcal vaccine, and among 337 current and former tobacco users with COPD only 5 (**1.4%**) had pneumococcal vaccinations in their record and **all five of those patients** also had HIV/AIDS. In 2013 we received patient-centered medical home recognition (PCMH) from the National Committee for Quality Assurance (NCQA) Level 3, 2011 standards. The PCMH model focuses on the reduction of care fragmentation arising from numerous referrals and a complex, overburdened system. Our overall goal is to use the PCMH concepts of pre-appointment planning, care coordination, and data population management to address the immunization disparity among this high risk population. Our evaluation process will include 1) selecting a family practice residency/primary care clinical team who will serve as the test group, utilizing data from the remaining teams as control groups; 2) work with the Health Information Technology (HIT) department on data collection methods and data reports to track results to changes in care delivery, and 3) document improved rates of pneumococcal immunization for tobacco users, and expand successes to other high-risk groups including those with chronic lung disease.

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**C. Main Section of the proposal (not to exceed 12 pages):**

**3. Overall Goal & Objectives: Describe the overall goal for this project. Describe how this goal aligns with the focus of the RFP, the goals of the applicant organizations and the proposed project. List the key objectives and how they are intended to address the established need for this project. Do not include learner objectives.**

**Goal:**

Develop an innovative process based on patient-centered medical home concepts that includes agency-wide involvement resulting in the elimination of disparities in adult pneumococcal immunization among tobacco users. The following table provides a crosswalk between our project goals and the goal of the RFP; key objectives follow the table.

<b>RFP focus</b>	<b>Applicant Goals</b>
Increasing immunization against pneumococcal disease in at-risk adult populations	Increasing rates of pneumococcal immunization among tobacco users age 19 to 64
Focus on disparities of care resulting from the geographic distribution of healthcare services	<ul style="list-style-type: none"> <li>Reach rural patients whose tobacco use is high</li> <li>Engage family medicine residents in our rural-based program.</li> </ul>
Multi-disciplinary collaborations	<ul style="list-style-type: none"> <li>Work with the family medicine residency program and the Montana primary care association to share successes and lessons learned.</li> <li>Consistent with PCMH principles engage <i>all</i> team members across disciplines in reaching project goal.</li> </ul>
Interventions will be evidence-based (education and/or quality improvement)	Project is based on PCMH and evidence-based concepts including care coordination and data population management.
Proposed research/evaluation will follow generally accepted scientific principles	<ul style="list-style-type: none"> <li>Initial project will be studied in one of four primary care teams who will serve as a test group; remaining teams serving as control groups.</li> <li>Plan-Do-Study-Act (PDSA) QI principle is used to document all changes and outcomes.</li> </ul>
Directly impact patient care	Improve rates of immunization among smokers aged 19 to 64 from 0.8% to 40% in Year One, with ultimate goal of 65%.
Programs that utilize system-based changes	<ul style="list-style-type: none"> <li>Recent system based changes that resulted in PCMH 2011 Level 3 recognition will be applied to mitigate the disparity in immunization rates among our target population.</li> <li>Develop a process to eliminate the cost barrier by linking patients to resources through our medication assistance program.</li> </ul>

**Key Objectives and how they meet the established need for this project:**

**Objective #1:** Identify pneumococcal immunization disparities among high risk patients with co-morbid conditions – as noted in our abstract, this has been completed and showed a significant disparity between tobacco users and other high-risk populations at our health center. Ongoing tracking of disparities among tobacco users and other co-morbid conditions such as lung disease and cardiac disease will be included in the project.

**Objective #2:** Identify family practice residents and primary care clinical teams to address unique disparities – involving the entire team allows for in-put and buy-in from all levels of the

care team consistent with PCMH principles. Involving the family practice residency in the design and implementation of the project ensures best practices regarding immunization and follows them to their practices in Montana's rural/frontier communities.

*Objective #3:* Work with the IT department on data collection methods in eClinicalWorks (eCW), our electronic medical record (EMR), to insure quality reporting for the QI project – data population management is a key PCMH concept that guides system change across a targeted group as opposed to just improving and individual's care. Additionally, tracking success through care coordination improvements will be done through structured data reporting.

*Objective #4:* Adopt the PCMH change concepts that were successfully used in creating an environment for cross-department improvement ideas in the realms of HIV and diabetes care and apply them to the immunization project – at PHC, our rates of immunization among patients with diabetes and patients with HIV/AIDS are significantly higher than among our general population who use tobacco. As high risk patients who currently receive care management, applying those same principles of pre-appointment planning and care coordination that we use in working with our diabetics and patients with HIV, should result in the same outcomes among tobacco users.

*Objective #5:* Improve rates of pneumococcal immunization for high-risk groups including those with tobacco use – we are confident that applying PCMH principles system-wide in targeting smokers we will have the same successes we have seen in applying this model of care to other high-risk populations. If we can show that success we will expand to include patients with chronic lung disease and cardiac patients.

***3. Technical Approach: Describe how this project will meet the goal of the specific area of interest for the RFP. The RFP includes a national assessment of the need for the project. Please do not repeat this information within the proposal (you may reference the RFP if needed). Only include information that impacts your specific project, linking regional or local needs to those identified on the national basis if appropriate.***

***a. Current Assessment of need in target area***

***Please include quantitative baseline data summary, initial metrics (e.g., quality measures), or project starting point (please cite data on gap analyses or relevant patient-level data that describes the problem) in your target area. Describe the source and method used to collect the data. Describe how the data was analyzed to determine that a gap existed.***

***i. Quantitative baseline data summary.*** Consistent with the national data in the Pfizer RFP we used our electronic medical records system, eClinicalWorks (eCW) to identify rates of pneumococcal vaccine in a number of different patient groups. Our rate of immunization among patients over 65 was at **65.3%**, lower than the Healthy People 2020 (HP2020) goal of 90% but consistent with the national averages for whites as noted in the RFP. Among 18 to 64 year olds we looked at a few subgroups of patients with co-morbidities and found some significant disparities. **59.6%** of our 18 to 64 year olds with **diabetes** had received a pneumococcal vaccine, and **95.3%** of patients with **HIV/AIDS** were up to date on their pneumococcal vaccines. However among 3,790 current tobacco users only 31 (**0.8%**) had documented pneumococcal vaccine, and among 337 current and former tobacco users with COPD only 5 (**1.4%**) had pneumococcal vaccinations in their record and **all five of those patients** also had HIV/AIDS. In looking at current quality improvement data routinely tracked in eCW and reported to our Performance Improvement (PI) committee, the difference

between our patients with lung disease and those with diabetes, or those using tobacco and those with HIV/AIDS is the structure of widespread support, nutrition and care management available to patients with diabetes and HIV. What makes these populations different in our system is the participation in national/statewide ongoing QI projects and a well-established team of providers and support staff. In 2013, we received patient-centered medical home (PCMH) recognition from the National Committee for Quality Assurance (NCQA) at Level 3, 2011 standards. As a part of our patient-centered medical home process, we learned that true transformation in any quality process is more likely to be successful if PCMH change concepts are followed for *all* organizational quality improvements. The unique requirements of organizational transformation for PCMH includes involving the **entire organization** in all process improvements.

**ii. Describe the primary audience(s) targeted for this project. Also describe who will directly benefit from the project outcomes.** Survey results from the 2011 Montana Behavioral Risk Factor Surveillance System (BRFSS)—the most recent available—indicate that in 2011, 22.1 percent of Montana adults were currently smoking most days or every day and 7.1% of Montana adults were using smokeless tobacco (i.e. chew, snuff, or snus) most days or every day. Across all states and D.C., the prevalence of cigarette smoking among adults ranged from 11.8% to 29.0%. Montana ranked 32<sup>nd</sup> among the states. Across all states and D.C., the prevalence of using smokeless tobacco ranged from 1.4% to 9.8%. Montana ranked 46th among the states.<sup>1</sup> The following sociodemographic trends were noted:

- The prevalence of current smokeless tobacco use was significantly higher among men than women.
- Older adults reported to regularly smoke cigarettes or to use smokeless tobacco less often than younger adults.
- Current smoking decreased with increasing education and household income levels.<sup>2</sup>

The 2011 BRFSS also showed that among adults aged 35+ years, over 1,400 died as a result of tobacco use per year, on average, during 2000–2004. This represents a smoking-attributable mortality rate of 276.0/100,000. Montana's smoking-attributable mortality rate ranks 32<sup>nd</sup> among the states.<sup>3</sup>

A positive indicator that we can build on is that according to the CDC in 2011: *Best Practices* estimates 8% of smokers could access quitlines each year. In Montana, 9.7% of smokers called their quitline, ranking third among the states. The range across the states at that time was from less than 1% to 10.9%.

Partnership Health Center and the Family Medicine Residency of Western Montana see about 10,000 patients a year. With a newly renovated building that doubled our existing clinical space

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<sup>1</sup> United States. Centers for Disease Control and Prevention. State Tobacco Activities Tracking and Evaluation (Montana) System. <http://apps.nccd.cdc.gov/statesystem/ReportTopic/ReportTopics.aspx#Nav100>

<sup>2</sup> Montana Department of Public Health and Human Services. Survey Results from the 2011 Montana Behavioral Risk Factor Surveillance System. <http://www.brfss.mt.gov/>

<sup>3</sup> Ibid.

in January of 2014, and the doubling of the number of family medicine residents in the program from ten to twenty residents this July, we anticipate serving an additional 5,000 family practice patients by 2015. The numbers of patients in our baseline data sets in this letter of intent, included 415 patients over 65 seen in 2013, 623 patients with diabetes; 3,790 current smokers and 337 patients with a primary diagnosis of COPD. Our initial target audience will be tobacco users age 19 to 64 but will expand to include all patients with co-morbid conditions who have not been offered the pneumococcal vaccine, including, but not limited to, those with asthma and congestive heart failure. In our project, led by dynamic family medicine residents and faculty, we will look at subgroups based on age, gender, ethnicity, insurance status, distance to health services, and co-morbid conditions. We believe the health center patients will be the most obvious group that will directly benefit from this project, however, as has been our practice in Montana, we share all QI projects and outcomes with the fourteen other federally qualified community health centers in the state through ongoing QI projects in collaboration with the Montana Primary Care Association (MPCA). Noted in this budget, the MPCA has offered an in-kind donation to cover the costs of webinars or face-to-face meetings where we will share lessons learned. The FMRWM, as a newly established academic institution, will provide the opportunity for family medicine residents to learn about how to engage in continuous quality improvement activities so that they may continue to apply those methods and skills in their practices after graduation.

***b. Project Design and Methods: Describe the way the project planned addresses the established need and produces the desired results.*** *Our project design includes addressing system, primary care provider, and patient barriers. Strategies are outlined below:*

- No system or structure ensuring vaccination in adults. Strategy: Identify the best point of care for offering vaccine:

While PHC has received PCMH recognition many changes require on-going tracking of adherence to the new models of care, and frequent staff/patient reminders about why systems are designed as they are. If funded, the project will engage all members of one primary care team (medical assistants, midlevel providers, a primary care “backbone” physician, a faculty physician, two residents and two receptionists in a planning and kick-off meeting. These meetings will be facilitated by the project lead and HIT Director. The plan will be to look at all points of care: pre-appointment planning “huddles,” patient check-in, rooming of the patient, intake by the nurse/MA, and provider visit – and determine how tobacco users are identified and how the system can best “flag” or alert the provider to the need for the pneumococcal vaccine. Our current PCMH has resulted in significant improvements of 10 % or more across other preventive services such as mammograms, cervical and colo-rectal cancer screening and we feel confident applying these same principles to IZ rates will be successful.

- No system or structure ensuring vaccination in adults. Strategy: Adapt system wide PCMH practices to improve IZ rates for smokers:

One system wide change considered critical to our preventive care quality improvements is the huddle. As part of PCMH we created three points for huddling: before morning clinic, before afternoon clinic, and at the end of the day. Although we have a good rate of screening for tobacco use (75% to 90% of the population depending on the measurement period, and consistently high rates of recommending cessation, we do not have any linkage to an alert for the pneumococcal vaccine. In an EMR already filled with alerts and warnings we would

brainstorm with the entire team for the best point of care reminder to ensure it is identified at the most reasonable time in the visit to allow for maximum education and buy-in of the patient. It is true that Montana is home to a tobacco-loving culture resulting in more than half of all patients identifying as a smoker. Whether it is the rugged image of the “Marlboro Man,” the ceremonial reverence of the American Indian culture, or as a coping mechanism for widespread depression, conversations about cessation are often met with a vehement *no*. This makes immunization even more critical for this population. However, in the March 2014 issue of the web-based Family Practice Management magazine, an article called “Resolving Patients’ Vaccination Uncertainty: Going from ‘No Thanks’ to ‘Of Course,’” confirmed that the number one way to impact whether or not the patient accepts vaccination is if the medical provider suggests it. A 2009 IZ study of the National Foundation for Infectious Diseases showed the decision to accept the vaccine was 69% if suggested by the personal physician. We believe this is true from our current practice experience and making system, wide changes that allows that message to be in the providers mind during the visit, will result in the best possible outcomes.

- Lack of Awareness of the Advisory Committee on Immunization Practice (ACIP) guidelines. Strategy: Provide patient/staff education about the importance of pneumococcal vaccine among smokers:

It is easy to understand how, in a busy clinic, where the majority of patients present with significant co-morbid conditions, that a fairly well young to middle-aged person’s visit may escape the radar for preventive IZ. We will utilize the team meetings to educate and if improvements are seen at the rate we expect to see them, then expand the education from the test group to our health center staff both in Missoula and at our rural Seeley Lake satellite. While we view the non-test teams as control groups, we realize it won’t be pure because there’s always some peripheral improvement when a change is in close proximity.

- Patient concern about cost. Strategy: A process for linkage to our in-house medication assistance program (MAP).

In Montana, Medicaid expansion did not pass the legislature, leaving a significant number of people who are still considered part of our safety net medical home group. Roughly 60% are still self-pay patients and cost is a real concern. In our HIV population, where all but five patients are now insured, 95% have been immunized.

- Health Literacy Strategy: The development of patient materials that considers cultural and reading levels.

In moving towards PCMH recognition, we established a practice of asking all patients about the best way to deliver information. Additionally, more than a third of our patients are registered for the web portal and we also have a significant number with access to email. We will create a survey monkey to ask about attitudes or myths related to vaccination and use these responses in the design of education materials.

### ***c. Evaluation Design***

#### ***i. In terms of the metrics used for the needs assessment, describe how you will determine if the practice gap was addressed for the target group.***

- *Identify the sources of data that you anticipate using to make the determination.* Partnership Health Center has an IT department who has helped us maximize data population management through structured data reports generated by eCW, our EMR is our current source for all these relevant data.

- *Describe how you expect to collect and analyze the data.* Project staff will work with the HIT department to develop a template with structured data fields that will help us determine not only if the target population was identified through system changes but include searchable fields about whether or not the IZ was offered, accepted, and if not accepted, the reason for decline. Consistent with all quality improvement projects, progress is reported monthly to our Performance Improvement (PI) committee. At the PI monthly meetings, whenever goals are not being met, the committee offers feedback and strategy suggestions to help improve outcomes.
- *Identify the method used to control for other factors outside this project (e.g., use of a control group)* our initial project kick-off will be focused on one of four primary care teams. We have some concern in the purity of the term “control group” since all primary care teams share the same physical clinic space and we expect there will be some “cross-contamination” of new methods and knowledge, however, we will independently track the target group and outcomes of all four teams, expecting that the test group will see improvements earliest and in the greatest numbers, at which point we will consciously expand the project to include these teams and the team at our rural satellite.

***ii. Quantify the amount of change expected from this project in terms of your target audience (e.g., a 10% increase over baseline or a decrease in utilization from baseline between 20-40%)*** PHC proposes an increase from 0.8% to 40% in the first year. We anticipate being able to document 65% of the smokers will be offered the IZ, but historically about a third of our patients initially decline. Our ultimate goal will be 65%. We hope the outcome will be on the higher side but because our baseline is so low (0.8%), acceptance of the vaccine is an unknown.

***iii. Indicate how you will determine if the target audience was fully engaged in the project.*** The most obvious way will be a dramatic improvement in the numbers of tobacco using patients aged 19 to 64 being offered, and accepting, the vaccination. Additionally, PHC and the FMRWM survey our patients monthly either by phone or survey monkey. The IZ improvement teams will develop brief surveys after each system change, and create a random sampling process for de-identified patient feedback. Consistent with our PCMH practices, we also involve our patient-family council for feedback of all organizational change. Summaries of patient responses are provided to our performance improvement committee and our Board of Directors.

***iv. Describe how you plan for the project outcomes to be broadly disseminated.*** At PHC, we have a number of regular venues for sharing clinical practice improvements: a bi-monthly clinic management meeting, weekly residency didactic sessions, twice monthly nurse education meetings, and twice monthly clinic meetings. As noted earlier in this proposal, we routinely work with the Montana Primary Care Association to share strategies and best practices with the other federally qualified health centers (FQHCs) in Montana. We were a key resource for each other during the PCMH Demonstration projects in 2013 and would share successes and lessons learned during this project. The MPCA will donate in-kind meeting materials and webinars to share our strategies and outcomes with Montana’s FQHCs.



2. **Detailed Workplan and Deliverables Schedule: Include a narrative (which counts toward the 12-page limit) describing the work plan and outlining how the project will be implemented over the X-year period. Using a table format (no page limit), list the deliverables and a schedule for completion of each deliverable. In the budget, associate each of the deliverables to a specific dollar amount. (See Work Plan)**

**WORK PLAN**

<p><b>Focus Area:</b> No system or structure ensuring vaccination in adults</p> <ul style="list-style-type: none"> <li>• <b>Strategy # 1:</b> Identify the best point of care for offering vaccine:</li> </ul>			
<b>KEY ACTION STEP</b>	<b>PERSONAL RESPONSIBLE</b>	<b>TIME FRAME</b>	<b>COMMENTS</b>
1. Work with representatives from the IT department, family medicine residency (FMRWM), and primary care medical teams to identify how patients can best be identified and flagged as needing the vaccine.	Director of Integration, HIT Director, Project Principle Investigator (PI)	Within 30 days of grant award show planning and kick-off meeting minutes, template designs.	<ul style="list-style-type: none"> <li>• Meeting minutes on file</li> <li>• Templates active</li> </ul>
2. Ongoing engagement of critical team members for feedback and CQI.	Director of Integration, HIT Director, Project PI	<b>Year 1:</b> Monthly team meetings of test group members to assess progress through review of PDSAs looking at system wide changes.	<ul style="list-style-type: none"> <li>• Disseminate monthly reports across the clinic care teams.</li> <li>• Ongoing monthly reports to the Performance Improvement committee on file with quality improvement interventions if not at goal.</li> </ul>
<p><b>Focus:</b> No system or structure ensuring vaccination in adults.</p> <ul style="list-style-type: none"> <li>• <b>Strategy:</b> Adapt system wide PCMH practices to improve IZ rates for smokers:</li> </ul>			
Develop template for huddles which includes targeting smokers and flagging eh provider to offer vaccine.	IT Director, Director of Integration, PCMH Community Health Specialist	Within 30 days of grant award develop template and within 60 days train key staff in use of template.	<ul style="list-style-type: none"> <li>• Post training staff competency forms on file.</li> <li>• Training materials on file.</li> <li>• Staff training schedule on file.</li> </ul>
<p><b>Focus:</b> Lack of Awareness of the ACIP guidelines.</p> <ul style="list-style-type: none"> <li>• <b>Strategy:</b> Provide patient/staff education about the importance of pneumococcal vaccine among smokers:</li> </ul>			

Develop culturally and linguistically appropriate materials for patient education	Director of Integration, PCMH Community Health Specialist, Project PI	Within 30 days of grant award develop materials and within 60 days of grant award document feedback of Patient-Family Council and disseminate to staff.	<ul style="list-style-type: none"> <li>• Training materials on file.</li> </ul>
<p>Focus: Financial Barrier: Patient concern about cost.</p> <ul style="list-style-type: none"> <li>• Strategy: A process for linkage to our in-house medication assistance program (MAP).</li> </ul>			
Implement a process for self-pay patients to engage in MAP	MAP staff, Project PI	Within 90 days of grant award establish a process for identifying financial barriers and linkage to MAP program.	<ul style="list-style-type: none"> <li>• Policy and procedure on file.</li> <li>• Staff training schedule on file.</li> </ul>
<p>Focus: Identify data source and process for collecting and analyzing data</p> <ul style="list-style-type: none"> <li>• Strategy: Add data reporting to PI Committee</li> </ul>			
Implement ongoing meetings to address data collection challenges, track improvements, and study rates of disparity across clinic comparing the test team with other teams, associated co-morbid conditions, and age, race, and ethnicity.	IT Director, Director of Integration, PCMH Community Health Specialist	Within 90 days of grant award establish a process for reporting on the project, and develop a format for the reports.	<ul style="list-style-type: none"> <li>• Reports on file.</li> </ul>
<p>Focus: Evaluate engagement of the target population</p> <ul style="list-style-type: none"> <li>• Strategy: Survey patients utilizing a variety of methods</li> </ul>			
Present project strategy to the patient-family council (PFC)	IT Director, Director of Integration	Within 60 days of grant award request feedback on project materials and strategies	<ul style="list-style-type: none"> <li>• PFC meeting minutes on file.</li> </ul>
Develop a message for target population members using the web portal	IT Director, Director of Integration, PCMH Community Health Specialist	Within 60 days of grant award identify current patients age 19 to 64 who are tobacco users and send a vaccine reminder through the patient portal	<ul style="list-style-type: none"> <li>• Web message part of EMR, document random chart audit of web message</li> <li>• Document number of patients getting vaccine who received a web portal reminder</li> </ul>
Create a survey monkey to assess acceptance of the vaccine, understanding of the need for the vaccine, and myths that may be a factor in acceptance.	IT Director, Director of Integration, PCMH Community Health Specialist	Within 90 days of grant award identify current patients age 19 to 64 who are tobacco users and have an active email address and send a survey monkey	<ul style="list-style-type: none"> <li>• Survey results on file</li> </ul>

## **A. Organizational Detail (not to exceed 3 pages)**

**1. Leadership and Organizational Capability. Attributes of PHC and FMRWM that will support and facilitate the execution of the project.** As a 501(c)3 non-profit organization and the only federally-qualified health center in Missoula County, PHC operates its main clinic sites in Missoula (PHC-Alder and PHC-Creamery), in addition to a clinic at the local homeless shelter; the first school-based health center in the state; and a new access point clinic in Seeley Lake, a rural community located 60 miles from the City of Missoula. We have recently completed our PHC-Creamery clinic building renovation and expansion project. This phased, multi-year project answers Missoula County's desperate need for expanded medical services for underserved residents. All clinical services have been moved from the older Alder building (which is now the administrative building) to the new Creamery clinic. This physical integration has greatly enhanced our patient centered health home model that provides evidence based care in every facet of our healthcare delivery system. At full capacity, the renovated and new space will allow us to almost double the number of patients currently being served in our clinics, increasing patient volumes by 9,000 (to approximately 20,000) within three years.

PHC and the newly-created FMRWM are just completing our first year of a dynamic relationship. The residency, by year three, will have 30 family practice residents preparing to serve our most geographically isolated rural/frontier areas. Montana currently has an extreme shortage of primary care physicians with 54/56 counties officially designated as a Health Professional Shortage Area (HPSA). Moreover, 11/56 counties are not served by any family or general practitioners at all (Source: Montana Healthcare Workforce Statewide Strategic Plan 11/1/11). We believe funding this project—which we expect will help us to learn all we can about process design that fully engages our target audience in preventive immunizations such as pneumococcal vaccines—will potentially bring a higher level of care, through the efforts of our rural-focused residents to significantly underserved areas of Montana with long-lasting change to healthcare delivery in our impoverished state.

Moreover, in the past six years, PHC has implemented expansions in the medical and dental clinics, the pharmacy, and mental health services programs; established a residency program to bring primary care residents to PHC for training in public health medicine; submitted our application to the National Center for Quality Assurance Patient Centered Medical Home recognition (NCQA) and have received PCMH 2011 Level 3 Recognition; received funding to establish the first school-based health center in the state, a collaborative project between PHC and the Missoula County Public Schools; were selected by the University of Wisconsin and Dartmouth College to participate in a study using new technologies in the treatment of substance abuse funded by the National Institute for Drug Abuse (NIDA), a division of the National Institutes for Health (NIH). We are one of three federally qualified health centers in the country who are participating. This past summer, PHC was selected by the John A. Hartford Foundation as one of three rural public health clinics in the country to implement the IMPACT (Improving Mood—Providing Access to Collaborative Treatment), an evidence-based model for integrating physical and mental health within the context of medical health homes such as ours for disadvantaged individuals. We have significant technical assistance support through the Advancing Integrated Mental Health Solutions (AIMS) Center in Seattle.

The process that we used towards achieving PCMH 2011 Level 3 recognition and implementing its best practices also demonstrates our strength in implementing programs that

will prove helpful in implementing the Pfizer program. In November, 2010, PHC's Quality Improvement Committee began working towards PCMH recognition. The committee's work began with the completion of the self assessment tool on the National Center for Quality Assurance (NCQA) website. In that process, we identified a number of organizational strengths and also noted areas that would need to be improved prior to submitting our application. Having successfully transitioned to an electronic health record system in June, 2009, we realized we would first want to maximize our reporting capabilities. We formed an in-house task force which met weekly, and identified a leadership team member to attend the NCQA training "Facilitating PCMH" in May, 2011. We have continued to implement the PCMH model's patient-centered approaches ever since. The entire process has been a quality improvement activity for our organization and has facilitated sustainable organizational change.

Implementation of the above programs has required organizational change, a challenge that we have continuously met. The integrated model of care features of the Pfizer project are similar to those involved in the recent implementations of patient-centered medical home and residency programs.