

**Integrative Patient-Centered Medical Homes: A Profile of The Center for  
Natural Medicine**

**Prepared by**

**Jennifer Olejownik**

**The Academic Collaborative for Integrative Health (ACIH) as part of  
The Project for Integrative Health and the Triple Aim (PIHTA)**

**Sponsored by**

**The North American Board of Naturopathic Examiners (NABNE)  
Visual Outcomes**

**December 12, 2016**

## INTRODUCTION

This document represents the first installment of a three part series focusing on naturopathic doctors as primary care providers working in Integrative Patient-Centered Medical Homes. In recent years, the convergence of “values-based medicine” under the Affordable Care Act and the rise of integrative health and medicine have increased the opportunities for integrative health providers. However, the roles of the profession that can claim to have first modeled integrative medicine, naturopathic physicians, is modeling these new forms of care are often invisible. This project is meant to help remedy that by creating, posting, highlighting and publicizing a sequence of resources that will become a go-to resource for all stakeholders in understanding these contributions of naturopathic doctors.

The entire project has 3 significant purposes: 1) educate members of the naturopathic profession to these roles for naturopathic physicians; 2) provide guidance for any naturopathic doctors who wish to pursue a professional role in a PCMH or FQHC; and, most importantly, substantially increase awareness that naturopathic physicians have significant roles to play as leaders, and as part of teams, in meeting the nation’s primary care needs. The individual case study reports from each clinic are not only intended for integrative providers interested in assuming employment in these settings, but are also for educators, administrators, and other stakeholders to better understand what behaviors and skills are needed to prepare graduates to work in medical homes.

### ***Project Background***

Given the context of the dramatically changing health care landscape, the integrative healthcare professions (IHPs) – naturopathic doctors (NDs), chiropractors (DCs), acupuncturists (LAc)s- will play a pivotal role in reducing health care costs, enhancing patient experience, and improving health care (Triple Aim) outcomes while promoting a culture of health and well-being. The patient-centered medical home (PCMH) is a model that has significant potential to improve health care by restructuring how primary care is organized and delivered. PCMHs are closely aligned with the values of integrative health and medicine as they represent a comprehensive, collaborative, team-based approach to care while also focusing on accessibility and coordinated services (Table 1)<sup>1</sup>. Although care in this model has been solely structured around conventional primary care physicians, a few unique new models within the PCMH framework are beginning to evolve that include IHPs as primary care providers. Models like the integrative PCMH (IPCMH) challenge the long-held cultural belief that medical doctors, physician assistants and in some states nurse practitioners, are the only professionals well-qualified to lead PCMHs. Thus far, two states, Vermont and Oregon, recognize NDs as primary care providers eligible to lead PCMHs. Because of the anticipated shortage of primary care physicians in the U.S. and the need to shift our health delivery system to focus on health and well-being, it is an auspicious time to consider innovative models to better understand how integrative providers could help fulfill this shortage while simultaneously contributing to the goals of the Triple Aim and building a culture of health and well-being<sup>2</sup>.

---

<sup>1</sup> Adopted from <https://pcmh.ahrq.gov/page/defining-pcmh>

<sup>2</sup> <https://integrativehealth.org/primarycareproject>

**Table 1. Central Features of PCMHs (Agency for Healthcare Research and Quality)**

Comprehensive Care	The primary care medical home is accountable for meeting the large majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive care requires a team of care providers. This team might include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators. Although some medical home practices may bring together large and diverse teams of care providers to meet the needs of their patients, many others, including smaller practices, will build virtual teams linking themselves and their patients to providers and services in their communities.
Patient Centered	The primary care medical home provides health care that is relationship-based with an orientation toward the whole person. Partnering with patients and their families requires understanding and respecting each patient's unique needs, culture, values, and preferences. The medical home practice actively supports patients in learning to manage and organize their own care at the level the patient chooses. Recognizing that patients and families are core members of the care team, medical home practices ensure that they are fully informed partners in establishing care plans.
Coordinated Care	The primary care medical home coordinates care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports. Such coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital. Medical home practices also excel at building clear and open communication among patients and families, the medical home, and members of the broader care team.
Accessible Services	The primary care medical home delivers accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication such as email and telephone care. The medical home practice is responsive to patients' preferences regarding access to care.
Quality and Safety	The primary care medical home demonstrates a commitment to quality and quality improvement by ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide shared decision making with patients and families, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population health management. Sharing robust quality and safety data and improvement activities publicly is also an important marker of a system-level commitment to quality.

The current model with physician-led PCMHs assumes that MDs have an intricate understanding of the values and practices needed to transform our fractionalized, disease-based health care system to one that is organized around the principles of prevention, health and well-being. With at least 75% of our 3.2 trillion dollars spent on healthcare towards preventable and/or chronic conditions and lifestyle issues, it is time to shift the American health delivery system to focus significantly more on the promotion of health and well-being<sup>3</sup>. Logically, it makes sense to incorporate systems, disciplines, and professionals that already have the knowledge, skills and training to focus on disease prevention and health creation. Integrative Health Providers (IHPs) excel in promoting a culture of health because they undergo in-depth training focused on wellness and prevention, as well as using a less invasive approach before recommending a more invasive one. IHPs emphasize the promotion of self-care, build partnerships with patients, and allow time for office visits that focus on whole person care.

<sup>3</sup> <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>

Furthermore, IHPs impact patient populations through lifestyle and behavior strategies, but these contributions have largely been under-represented in research, funding and scholarship.

The Academic Collaborative for Integrative Health (ACIH) has received numerous requests from practitioners, stakeholders and constituents wanting to not only know how to start a PCMH, but also how to adopt and incorporate the best practices related to this new and emerging medical model. To broaden our understanding of these clinics, Visual Outcomes and the North American Board of Naturopathic Examiners (NABNE) generously funded this project to explore the role of naturopathic medicine in integrative Patient-Centered Medical Homes (IPCMHs) around the country. The Project for Integrative Health and the Triple Aim (PIHTA), a priority initiative of ACIH, compiles and shares an ever expanding list of IPCMHs in the United States on its website<sup>4</sup>. Due to the collaborative nature ACIH has with existing clinics on this list, 3 were selected to study: The Center for Natural Medicine, Portland, OR, The National University for Natural Medicine, Portland, OR, and Mountain View Natural Medicine, South Burlington, VT. These clinics are located in Oregon and Vermont, two of the most progressive healthcare states in the nation, where naturopathic doctors are eligible to lead PCMHs. Because there exists a paucity of documentation and literature on IPCMHs, this report was drafted as an exploratory attempt to understand some of the issues, barriers, successes and challenges related to the operation of these environments. This document represents findings from conversations held with naturopathic doctors and other integrative providers working in an IPCMH. The information presented below is a broad overview of the Center for Natural Medicine as told by providers working in this setting.

## Methods

Due to the exploratory nature of this project, qualitative methods were used to capture relevant information from three IPCMHs led by naturopathic doctors. Interviews were conducted with staff working within these clinics as a data collection strategy to capture and catalogue information about their experiences, struggles and successes. Interviews were first conducted with administrators to provide an overview of the project also to identify other staff members who might be available to be interviewed. Although the intention was to interview naturopathic doctors working in these settings, we were also inspired to learn from other providers and administrative personnel that comprise the IPCMH organizational structure. At times, administrators recommended we speak with office personnel, data managers and other levels of management to better understand the intricacies involved in maintaining an IPCMH. In other instances, different types of providers, such as licensed acupuncturists and nutritional counselors, were also nominated to be included in the interview process.

As a result, semi-structured interviews were conducted with staff and practitioners working within three selected clinics. Semi-structured interviews were favored for two reasons. Firstly, they diverge from a rigid line of inquiry and allow respondents to speak freely to share insights the interviewer may not have conceptualized or identified at the start of the project. Secondly, this process gives respondents a voice to shape the direction of the project which often yields new and unintended discoveries. An interview protocol was developed around a framework of specific themes to explore related to the challenges, successes, barriers associated with NDs working in an IPCMH. (A copy of the interview protocol is included in Appendix A at the end of this document.)

A total of six providers including naturopathic doctors, managers and other types of providers were interviewed at CNM for this project. Interviews were conducted over the phone with staff and

---

<sup>4</sup> <https://integrativehealth.org/examplesinpractice>

practitioners during the months of September-December 2015 and on average lasted between 30-60 minutes. Follow-up interviews were scheduled with selected respondents to gather more information or to clarify points that were previously communicated. Interviews for qualitative research purposes are normally recorded and transcribed for accuracy, but this process was not a possibility due to funding limitations. For record keeping purposes, detailed notes were captured in a blank interview form for each respondent at the time the interview occurred. To check the accuracy of the data and reporting, a copy of each clinic profile was sent to all respondents contributing to the project prior to dissemination to ensure each clinic was adequately captured. During this period, respondents had an opportunity to add, modify, or delete content.

Interview notes were read multiple times to identify major themes and trends. As themes emerged, they were sorted into various topics described in more detail below. To benefit other clinics wishing to become a PCPCH or PCMH, lessons learned will be summarized at the end of each section.

### **About the Clinic**

The Center for Natural Medicine located in Portland, Oregon is one of the leading naturopathic healthcare facilities in the Northwest and has been in operation since 1984. The center offers a variety of health care services including primary care naturopathic medicine and diagnostic testing, chiropractic care, acupuncture, massage therapy, and a large natural product dispensary. Its team of healthcare practitioners is diverse and is currently comprised of eight naturopathic physicians, twenty-four rotating 4th year naturopathic medical students, one chiropractor, four licensed acupuncturists, two licensed massage therapists, two office managers, three receptionists, and a nurse manager. The Center for Natural Medicine is also home of the Center of Excellence in Naturopathic Cardiovascular Medicine (COE) and Community Teaching Clinic. The COE is made up of a team of experts that provides leadership, best practices, research and training in naturopathic cardiovascular medicine. The Community Teaching Clinic mentors naturopathic students in cardiovascular and pulmonary medicine, research and training and was established in 1999.

### **Becoming a Patient-Centered Primary Care Home (PCPCH)**

Transitioning to a Patient Centered Primary Care Home (PCPCH) is a tedious process requiring many administrative steps and procedures, most of which are new to integrative health providers. "Any health care practice," according to the State of Oregon's website,<sup>5</sup> that provides comprehensive primary care and meets the key standards can become a recognized Patient-Centered Primary Care Home, including: physical health providers; behavioral, addictions and mental health care providers with integrated primary care services; solo practitioners; group practices; community mental health centers with integrative primary care services; rural health clinics; federally qualified health centers; and school based health centers.<sup>5</sup> In order for a clinic to be recognized as a PCPCH, they must meet standards established by Oregon's PCPCH Standards Advisory Commission that pertain to accessibility, accountability, comprehensiveness, continuous services, coordinated services, and patient and family centered care (Table. 2). There are 10 Must Pass Criteria established by the Oregon Health Authority and the National Committee for Quality Assurance (NCQA) to be recognized as a PCPCH that clinics must satisfy (Table 3). Once they are finally identified as a PCPCH, a renewal application must be submitted

---

<sup>5</sup> <http://www.oregon.gov/oha/pcpch/Pages/become-recognized.aspx>

every two years to maintain their status clinics. (For more information about this process, please review the Oregon Health Authority's *2014 Technical Assistance and Reporting Guidelines*<sup>6</sup>.)

**Table 2. Core Attributes of Oregon's PCPCHs identified by Standards Advisory Committee<sup>7</sup>**

<b>Accessible</b>	Care is available when patients need it.
<b>Accountable</b>	Practices take responsibility for the population and community they serve and provide quality, evidence-based care.
<b>Comprehensive</b>	Patients get the care, information and services they need to stay healthy.
<b>Continuous</b>	Providers know their patients and work with them to improve their health over time.
<b>Coordinated</b>	Care is integrated and clinics help patients navigate the health care system to get the care they need in a safe and timely way.
<b>Patient and Family Centered</b>	Individuals and families are the most important part of a patient's health care. Care should draw on a patient's strengths to set goals and communication should be culturally competent and understandable for all.

**Table 3. The 10 Must-Pass Criteria for PCPCH Recognition<sup>8</sup>**

<b>Standard</b>	<b>Criteria</b>
<b>Standard 1.C Telephone and Electronic Access</b>	1.C.0 PCPCH provides continuous access to clinical advice by telephone.
<b>Standard 2.A</b>	2.A.0 PCPCH tracks one quality metric from the core or menu set of PCPCH Quality Measures.
<b>Standard 3.B Medical Services</b>	3.B.0 PCPCH reports that it routinely offers all of the following categories of services: Acute care for minor illnesses and injuries; Ongoing management of chronic diseases including coordination of care; Office-based procedures and diagnostic tests; Patient education and self-management support.
<b>Standard 3.C Mental Health, Substance Abuse, &amp; Developmental Services</b>	3.C.0 PCPCH has a screening strategy for mental health, substance use, or developmental conditions and documents on-site and local referral resources.
<b>Standard 4.A Personal Clinician Assignment</b>	4.A.0 PCPCH reports the percentage of active patients assigned to a personal clinician or team. (D)
<b>Standard 4.B Personal Clinician Continuity</b>	4.B.0 PCPCH reports the percent of patient visits with assigned clinician or team. (D)

<sup>6</sup> <http://www.oregon.gov/oha/pcpch/Documents/TA-Guide.pdf>

<sup>7</sup> <http://www.oregon.gov/oha/pcpch/Documents/2014-2015%20PCPCH%20Program%20Annual%20Report.pdf>

<sup>8</sup>

<http://www.oregon.gov/oha/OHPR/Documents/2014%20PCPCH%20Recognition%20Criteria%20TA%20Guide%20FINAL%2010.4.13.pdf> (page 4)

<b>Standard 4.C Organization of Clinical Information</b>	4.C.0 PCPCH maintains a health record for each patient that contains at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record; and updates this record as needed at each visit.
<b>Standard 4.E Specialized Care Setting Transitions</b>	4.E.0 PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care.
<b>Standard 5.F End of Life Planning</b>	5.F.0 PCPCH has a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services.
<b>Standard 6.A Language/Cultural Interpretation</b>	6.A.0 PCPCH offers and/or uses either providers who speak a patient and family's language at time of service in-person or telephonic trained interpreters to communicate with patients and families in their language of choice.

It took CNM approximately 1.5 years to complete the steps required by the state of Oregon described above to achieve PCPCH status. At the time of the transition, patient load tripled and the clinic needed to double its staff to accommodate the increase in volume. Some providers were overwhelmed with the changes and decided that they were not suited to work in a PCPCH environment, prompting them to seek ultimately employment elsewhere. To support its transition to a PCPCH, the clinic also needed to develop and adopt a number of new processes and behaviors. One manager explained how her experience in hospital settings helped the clinic's transition to a PCPCH. She explained,

*There were a lot of changes being made and scrambling around. There was a huge learning curve for a lot of doctors. What I noticed is that smaller clinics don't have a full understanding of what I experienced [working in a hospital setting], so I was able to implement how to direct patients through hospital lists and how to keep patients out of the emergency room.*

The increase in patient volume also contributed to a major shift in the composition of the patient population. One respondent stated, "We were formerly seeing many people who were basically healthy. Now as a PCPCH, we have many people with multiple chronic conditions. Many are in poverty and no shows are a big deal for us." Another added that many patients at CNM did not initially come to the clinic specifically for natural medicine. He explained, "more than half of patients are assigned to us are though the government through Medicaid. They didn't necessarily choose natural medicine, but most of them are very happy with natural medicine. Most people do prefer medicine that uses both sides (CAM and conventional)." Another provider elaborated further about how the increase in Medicaid patients creates a diverse case load by saying,

*All of our providers are credentialed (as far as insurance companies go so we are covered by insurance. As far as Medicaid goes, all are credentialed with Medicaid. The state assigns us patients and every quarter we get assigned another group of patients. Overall, about 50% of clients are Medicaid clients. It is interesting because we see all different types.*

To accommodate the shift in patient load, the office manager revealed that the clinic adopted a number of organizational strategies to support this growth.

*We run a lot differently now. All rooms are exam rooms with a flag system. The patient comes in room and never leaves. Before [this system was in place] doctors all had desks in their own offices and it wasn't efficient enough and there was no flow and there were too many patients assigned to us to make it work. [As a result,] we standardized everything. Everything is the same and is run off the flag system. Each room is equipped with computers and the assistant starts charting as soon as the patient enters the room.*

The office manager took advantage of the changing climate and introduced other modifications to not only transform organizational culture, but to also remodel the physical space as well. She made changes to the property by painting, revamping the front desk, remodeling rooms, and by putting mobiles on the ceiling to make the interior space more inviting. At this time, a new billing program was introduced to improve efficiency and all staff were trained how to use it.

Building a culture of data is also an essential part of any clinic's transition to becoming a PCPCH. Similar to school teachers working in an era of accountability, health care professionals working in a PCPCH are required to document strategies used to demonstrate the key attributes related to quality. To maintain PCPCH status, clinics are required to provide evidence on how specific standards are being met. In practical terms, this means that providers working in a PCPCH must be aware of whether or not their assigned patients have received specific treatments, tests or procedures to satisfy the 10 Must Pass Criteria (See Table 3.) as well as any quality measures selected by the clinic. The result is that naturopathic doctors constantly must assess the status of each patient, determine what tests or procedures need ordered, and make sure patients receive appropriate care. Maintaining all this is akin to looking at a weather report each day; providers need information on a daily basis to prepare for the work they need to accomplish. Working with data in this capacity is a relatively new endeavor that requires extra administrative skills; these skills are not necessarily difficult, but they are extra tasks that providers must accomplish on top of providing care for their patients. Not only do providers need to know how to access patient lists, they must also be prepared to engage in ongoing communication with both patients and other providers, which can be rather time consuming. Providers occasionally need to send letters to specific patients to teach them how to manage chronic conditions or provide extra documentation required to treat Medicaid patients. One provider explained,

*A good proportion of patients at CNM are Medicaid, so there is a lot we do in terms of communicating data with them that is part of Medicaid's goals and requirements. We are in regular communication about these things. That's the way the government does these things. It is the same with insurance companies. We work with them and comply with their standards to maintain these relationships.*

The PCPCH framework mandates that all practices track at least one quality metric from a menu of PCPCH quality metrics listed in the *2014 PCPCH Recognition Criteria Technical Specifications and Reporting Guide*. CNM, a tier 3 PCPCH, selected three metrics that includes: better care for hypertension patients, continuous medication reconciliation, and increasing the number of patients among those assigned who are served. Recording metrics and meeting benchmarks has financial repercussions since accounting for more metrics equates with greater reimbursement for the PCPCH clinic.

In terms of daily operations, conversations with staff stated that ongoing support is necessary to ensure that the clinic runs smoothly. A naturopathic doctor identified one of the benefits of receiving assistance from others by saying, "Being in a larger group, a lot of things are handled by others which



frees my hands to focus on clinical aspects and I much prefer that. I would rather pay someone to do the more business aspects, dealing with insurance, scheduling." Another practitioner added, "[I] have support from the staff at the clinic who takes care of appointments, reception, and billing, and it works out well for me. I can focus on patients and not on business side of things, which can get complicated because we see all types of patients - Medicaid, cash, and insurance." Support, it seems, in this team-based environment can be reciprocal since providers also tend to assume supportive roles themselves. One provider explained, "I am very involved with most patients at clinic, but I can also run reports to see if docs are running reports. I do a lot of social work here if there are patients in crisis -- for example OHSU has resources to get patients into a bed in a hospital if need be. Things that a lot of docs don't know about that I do. I am a support in many ways."

Finally, for clinics considering becoming a PCPCH, there are a few lessons to glean from CNM's transition to a PCPCH. There may be changes in staffing due to growth or attrition or changes in patient composition so it is prudent to be aware of these possibilities ahead of time. New organizational processes and strategies for building an internal culture of data will need to be adopted to have the capability of tracking quality metrics. Fostering open lines of communication between providers and patients is essential as is providing ongoing operational support so providers are able to focus their efforts on patient care.

### **Technological Transition**

Technological transitions are not unusual for clinics on the verge of becoming a Patient-Centered Primary Care Home and this held true for CNM as well. In 2011, the clinic displayed its technological prowess by adding an electronic health record system (EHR) years before it applied for PCPCH status. Although this effort was indeed noteworthy and advantageous, there were still a few hurdles to overcome associated with being technologically fluent in this new era of healthcare. As one provider recounted, the "electronic health record system (EHR) is a major transition for those who have been charting on paper." When discussing the EHR, the office manager stated, "There is definitely a learning curve and it doesn't always meet our need the way we want it to." Most EHRs are designed to capture information from conventional medical providers and do not have fields to collect information from integrative health professionals. Quite often, integrative health providers using traditional EHRs need to manipulate data in order to run reports that are easily accessible for conventional providers using the same system. As a result, some integrative providers spend copious amounts of time modifying their existing EHR in order to produce data that is relevant and useful for daily operations.

Another provider talked about the challenges associated with learning how to operate within a new culture of data and accountability. He explained that while he did receive excellent on the job training from his supervisor, he supplemented the practical learning he obtained in the clinic by engaging in self-study routines when he was outside of the clinic. Specifically, he watched and studied videos and resources that were available online to learn more about how to use data and track metrics. Much like a patient engaged in his/her own healing processes, developing a culture of data requires that providers take ownership of this process and follow concepts that spark their curiosity.

Another complication associated with data collection and reporting that occurred at CNM was the switch to ICD-10 codes that recently occurred. Prior to October 1, 2015, CNM utilized the International Classification of Diseases that was created in 1979, commonly referred to as ICD-9, to classify diseases and other health problems prior to Oct. 1, 2015. While most of the industrialized countries adopted the new ICD-10 codes several years ago, the US transitioned fall of 2015. Changing from the ICD9 to ICD10

reporting system resulted in extra work for everyone at the clinic. While the new coding scheme offers more specificity in terms of reporting, the sheer number of codes has increased five-fold and the coding scheme itself has become more complicated, growing from a 5 character code to a 7 character alpha-numeric code. One provider mentioned how the change temporarily impacted patient experience by saying, "The biggest challenge for me was not learning how to do it, but learning how to do it without taking away connection from the patient because you are entering data while talking to a patient. It just takes time to learn." This suggests that patient experience may be impacted as providers learn new data techniques, but ultimately they are able to convert new procedures into seamless exchanges while maintaining the integrity of the doctor-patient relationship.

In regard to technological transitions, clinics interested in becoming a PCPCH should expect some challenges and struggles moving from a paper system to an EHR. Leaders may want to establish a network of resources on data and metrics and make them easily accessible so that providers are able to become more proficient in these areas on their own time. Lastly, maintaining connectivity with patients while adopting new technological procedures may be awkward at first, but with regular practice providers should expect to resume their typical style of relating and engaging with patients.

### **Collaboration and Referrals**

Practitioners at CNM had much to share about team-based care. This includes collaboration and the referral process as well as professional relationships with other medical providers. Sharing and referring patients internally is easily accomplished at CNM because everyone is credentialed with CareOregon, a nonprofit health plan serving the health care needs of low-income Oregonians. Credentialing simply refers to the process of verifying the qualifications of licensed professionals by evaluating their background and training for the purposes of determining eligibility to work in a specific setting. Since providers are credentialed through CareOregon they belong to the same network, which streamlines referrals as well as billing and reimbursement procedures. (For more information about this process, please see the [Care Oregon Credentialing](#) document located in the appendices at the end of this report.)

There are a number of benefits associated with being part of the CareOregon network. As a result of ongoing collaboration with CareOregon, CNM successfully forged relationships with colleagues there who were able to help the clinic secure additional funding. PCPCHs are responsible for motivating their assigned members to engage in preventative and health-related behaviors. When CareOregon announced that they were providing support to enhance patient engagement, CNM submitted an application and secured funding. During this time, the office manager noted that only about half of the patients assigned to the clinic had ever received care, and funds from the CareOregon initiative enabled the clinic to develop plans to better serve its patient population. Because of this support, a number of strategies were implemented including incorporating a text-based reminder system, educating patients about acupuncture and how it benefits specific conditions, and creating a quarterly newsletter marketed towards other clinics highlighting services offered. Lastly, CareOregon has been conducting ongoing research to determine the cost-effectiveness of PCPCHs. (For more information about cost, efficiency and Triple Aim measures for PCPCHs in Oregon, please see the document titled, *The Oregon Health Authority Patient-Centered Primary Care Home 2014-2015 Annual Report*, referenced at the end of this report. In this document CNM is featured collectively with other PCPCHs in Oregon.)

During conversations with staff at CNM, the practice of team-based care and how it relates to specialized care and collaboration with other providers was frequently mentioned. One practitioner elaborated on one advantage of working alongside other providers with different skill sets. She said,

*As a licensed acupuncturist practicing in a group, I am never seen for urgent or emergent care. No one comes in for broken limbs. I saw that in school. At CNM, we have primary care providers and nurses, who can handle urgent care or wound care, for example. I can still treat patients with diabetic neuropathy, but the patient relies on primary care providers to manage their blood sugar through medication, supplements and nutritional advice.*

As part of the team-based environment, a naturopathic doctor talked about the latent advantages of being around practitioners with different areas of expertise. He said,

*The best thing for me is being able to have people see different doctors for issues or conditions that are the most pertinent or specialized - the best person can help with aspects of a case. I do very little women's health, for example. What is just phenomenal is that the patients don't have to leave. They don't have to go to another clinic. We simply do an internal referral. We don't need to do anything with their insurance. I let the other doctor know what the appointment is for and we share a lot of patients. It is so nice compared to being at private clinic. There is more face to face and ongoing communication about patient care. I am able to discuss the case in more detail. The main primary care doctor is always kept in the loop more so than if they would be with an external referral. I never had the level of communication that I have now, and at CNM I can introduce a patient to a provider and they can meet them right away and shake their hands.*

Collaboration also occurs with providers and staff at regularly scheduled meetings at CNM. During these meetings, providers help drive content by submitting agenda items for discussion. In the past, topics have included clinic policies, guidelines for improvement, and complicated patient cases that merit discussion. One provider described an antidote highlighting how meetings foster ongoing collaboration and ultimately produce superior patient care. In this instance, a patient was being seen for pain management and the attending licensed acupuncturist found a suspicious cyst during treatment. Although she was not a primary care provider, she was able to immediately discuss the case with her colleagues and made a referral to a provider in the same building. Establishing a process to examine cases collaboratively promotes preventative care while enhancing internal collegiality.

When describing collaboration in clinical practice, naturopathic doctors revealed much about relationships and ongoing interactions with other types of medical providers outside of CNM. Overall, practitioners felt relationships with their medical counterparts are fairly positive and described how communication can be used as a tool to educate medical doctors about the field of naturopathic medicine. One naturopathic doctor explained,

*There is some tension with the MD world because they don't understand our schooling and what we learned, so what happens is we build bridges. When I send patients to a medical doctor, I write a description of treatment and what we did. For example, I got some patients off of hypertension medications by using herbs. So, doctors might be wary without this education. Quite often, patients go online and find a deal and buy supplements. Medical doctors don't have time to go into all of that in terms of interactions. They weren't really trained with supplement/herb interactions and we were and [my sense is that] MDs are grateful for that.*

She later provided more detail about how collaboration works when patients are referred to specialists and revealed some insights into the nature of relationships with other types of providers. She said,

*In most instances we do a lot of referrals, and I send my chart notes and requests for what I want them to do and they send me a treatment plan for what they want me to do. For example, there is a gastroenterologist who defers to naturopathic doctors for a more holistic approach. This is not the norm for sure, but it is encouraging. When there is a good primary care provider relationship they can use us for a good counseling resource without worrying that we are injuring their patients. I feel that when I refer to an MD or a specialist they respect my approach and I*

*will often get referrals from MDs who are sending their patients to an ND because they want different perspectives. I haven't really encountered resistance that I heard about in school. In school, we do a lot of rotations with specialists and MDs and they understand and utilize us well.*

The notion of team based care, as espoused on the CNM website, is part of its overarching philosophy which states that, "Each individual is a unique whole—a complex living organism consisting of body, mind, and spirit. Health is not merely the absence of disease, it is a state of optimal function."<sup>9</sup> In this context, team based care takes into account patient and family preferences. Patients or family members may decide to see specific providers and this process is streamlined by the receptionist who makes referrals based on each provider's areas of expertise. Delivering quality care and exceptional patient experience at CNM means that providers invest time with their patients during office visits, and providers report spending more time with their patients than their counterparts in conventional medicine. One naturopathic doctor explained,

*We treat the whole person. Here you see our medical director and he is going to ask a million questions that regular doctors don't.... In conventional medicine, doctors leave and medical assistants and nurses take over and answer all of the questions. Naturopathic doctors uncover the reasons about the causes of problems. This approach is different and we touch EVERY patient that comes through the door in some way. We offer everything under the roof (allergy testing, lab work, medications) so many things that are so different [than conventional medicine].*

Embedded in the statement above is the concept of modeling. When residents and other providers witness the medical director asking many questions to treat the whole person, his actions and behaviors establish expectations for clinical practice. This not only sets the tone for providers, but it creates expectations for patients and family members visiting the clinic as well.

CNM's experience with collaboration and referrals has much to teach providers wanting to work in a PCPCH environment. Networking and building relationships with other agencies and individuals may help clinics achieve financial support or guidance with reporting activities. Creating supportive and purposeful team-based environments will encourage deeper conversations and will lead to better patient care. When working with specialists or other providers outside of a medical home, it may be useful to educate attending physicians on naturopathic treatments a particular patient may be receiving to promote interprofessional collaboration. Finally, leaders who model the behaviors and skills they want to see in their clinic and staff also helps set expectations for patients and families as well.

## **Residency Program**

In partnership with the National University of Natural Medicine, CNM offers a residency program for naturopathic students that is supported by the Naturopathic Education and Research Consortium (NERC). As mentioned in the introduction, the teaching clinic trains naturopathic medical students in pulmonary and cardiovascular health and residencies are supervised by the medical director and CEO, Marty Milner, ND. Residencies last approximately six months and students work in a team environment with an assigned naturopathic doctor, other residents, and support staff.

The NERC website acknowledges that residencies for NDs are limited, but extremely necessary to prepare highly trained and competent professionals to work in diverse settings and contexts. The importance of residencies, or rather obtaining practical experience upon graduation, came up many

---

<sup>9</sup> <http://cnmwellness.com/about-cnm/>

times during interviews with staff and providers at CNM. Because CNM is a PCPCH, residents obtain a lot of practical experience working at the clinic due to its high patient volume. At the time the interviews were conducted, CNM had roughly 1200 patients assigned to the clinic, which means that residents have access to more learning opportunities than they would in settings without such a high patient volume. In addition to treating patients, residents at CNM communicated that they became more proficient in coding, ordering labs and tests, and how to report metrics.

As a result of the availability of residency programs, one naturopathic doctor felt that the naturopathic profession could be advanced by offering more opportunities for NDs to be primary care providers. She explained,

*I work in Oregon so I get to perform labs, order tests, and practice within my scope and what my license allows me to do. This is not the same in every state because licensing is really a state by state issue. Like Osteopathic Doctors (DOs), I anticipate we will be integrated into the system and we will be used as primary care providers (PCPs). We often hear the argument that there is no residency for NDs, but I did one. That's why insurance companies are balking calling us PCPs, but nurses and physician assistants are considered PCPs.*

For graduates wishing to work in primary care setting, it is highly recommended to pursue a residency prior to entering the workforce to gain more practical and hands-on experience. Selecting a clinic with a high volume of patients will ensure a wide range or varied cases to experience. In addition to patient care, students should also learn about coding, insurance, billing, ordering tests and labs, and quality measures. In order for graduates to have access to these kinds of opportunities, more schools and clinics should consider developing residency programs.

## **Advice**

When asked about providing advice to other providers interested in working in integrative PCMH environments, several themes emerged that pertain to education, insurance and the importance of being open to learning from conventional providers.

Some providers talked about the importance of speaking both languages, that is, having the capacity to engage and dialogue with all kinds of healthcare providers. One provider said, it is important to "figure out ways to talk to the other side of the fence. [I have] a friend who gives talks at a local university. There is a professor who talks about hand pain and [listening to that] I see the standard of care and [am able to] clarify with medical doctors where acupuncture is most beneficial in these situations." Additionally, having a background or another degree in medicine creates opportunities for engagement with other types of providers. For example, one naturopathic doctor discussed how having a background in medicine created an opportunity to forge ongoing relationships with medical providers. He also added, it is "beneficial for patients having access to both CAM (complementary and alternative) and allopathic medicine. They don't want either all of the time."

Other providers reinforced the notion of life-long learning by offering advice about enhancing educational opportunities after graduation. A few strongly recommended that providers learn more about insurance and billing. One naturopathic doctor said, with "insurance and billing, you need to constantly continue your education. It is either sink or swim because there are a lot of frustrations with billing." Another provider expanded on this idea by saying,

*It is important to familiarize yourself with insurance requirements. I don't feel we were educated to determine what level of visit you just did... You want that to be second nature to meet certain requirements....You can really lose money when you really did most of the work...I don't think that's something a student thinks about in school.*

Another talked about how changing insurance policies and the Affordable Care Act impact primary care eligibility for naturopathic doctors by saying,

*MODA (an insurance company) was denying primary care status to naturopathic doctors unless they did a residency. Insurance companies are changing policies twice a year, and this wasn't disclosed. When I was in school I wasn't thinking about credentialing, but it came out later. Each insurance company has different policies. The Oregon Board of Naturopathic Medicine is in a lawsuit against Healthnet. There is a law that says Oregon insurance can't discriminate against naturopathic doctors. In 5-10 years there will be a huge shift in policies and how that will work now because everyone needs to have insurance through the Affordable Care Act. It will change the landscape.*

Another practitioner discussed the importance of gaining hands-on experience outside of school with acute patients and the challenges of being financially sustainable after graduation. He said,

*One clinic [I worked at] focused on low income and more youth than old adults. I purposefully chose that due to the volume that goes through there. I saw lots of infections and learned how to treat them in a standard way. I wanted to do it because of the exposure to intense situation and patient contacts. I saw minimally 4-5 patients in [this clinic a day]- and this was not the case in other settings. You can't pay off your loans and stay alive.*

Practical experience gained as a result of patient volume was also expressed by another practitioner who stressed the importance of doing a residency after graduation. She stated,

*The success comes from knowing what you want to do when you are in school, which is hard to do when you are in school. Moving forward, if naturopaths are going to step up, we need residencies for every student. In school, there is a lot of focus on evidence based medicine; we learn many traditions. And now at NUNM, they have a Masters program, and I took a lot of research classes and they emphasize standard of care practices. I feel like, coming out of school, there was a big emphasis on standard of care -- what an medical doctor would offer in that situation and making sure that patients are offered the same and that we can offer alternatives as well. Not having a residency is a disservice because you don't get that kind of experience. If you are only seeing 1-2 patients per week so you don't get a lot of experience.*

She later cautioned about the perils of not having a residency by saying,

*The scary thing about being a naturopathic doctor...I was very lucky. I got out of school with the best opportunity out there. I just transitioned to a residency. I got a salary. I worked under a great mentor and I saw 60 patients a week. That is a minority. There are only 4-5 private residencies out of school of 100 where I see my own patients, that is different. They are on their own coming out of residency. They are not thinking about billing, insurance, starting practice, but if you are not a business person that is scary. A lot of colleagues, the first few years out of school struggled significantly, because they had to write a business plan and get started.*

Overall, staff at CNM had much advice to impart to parties either wishing to create a PCPCH or individuals seeking employment in these settings. To be a primary care provider in a PCPCH, it is extremely useful to be able to converse with all kinds of healthcare providers. To build these interprofessional bridges, it is beneficial to have a background in basic sciences or the capacity to develop strategies to network and learn from other types of providers. Successful providers are those who also happen to be life-long learners, so it is important to continue one's education after graduation

to learn more about billing, acute care, and the implications of specific policies that may impact your profession.

## **Successes**

When asked to describe or share stories of success as a result of working in a PCPCH environment, providers and staff at CNM had much to report. Overall, the successes identified coalesce around access to naturopathic care, reducing costs, and treating a variety of complex cases.

When asked about successes, the office manager said, "There are so many successes. One of the things that warms my heart are the patients who arrive in shambles and don't know anything about naturopathic medicine and you see them six months later and they look terrific. They never would have known we existed if we weren't a PCPCH." It is implied that this care would not be accessible or affordable if the clinic did not exist as a PCPCH. She added, "Building the clinic in the community helps us offer more than what we have offered before. We had to double our staff, but I think that the benefits are worth it on both ends. Patients are getting what they need, they are staying out of the ER and we are benefiting and we are able to grow and remodel. And costs are going down." Another provider added, "CareOregon which covers the Medicaid system is appreciating the cost benefits. We are limiting admissions and limiting admissions to the emergency room. People are desiring naturopathic and acupuncture care and requesting more holistic care." (For more information on the progress of Oregon's coordinated care organizations on quality measures, see Oregon's Health System Transformation CCO Metrics 2015 Final Report.)

One naturopathic doctor talked about the variety of experience gained while working in a PCPCH environment by sharing,

*I really like getting to see such a wide variety so I mean I have been able...when Medicaid became more available to people, there were a lot of people with more serious pathology and complex and interesting things as opposed to dealing with routine, mundane diagnoses that are handled right away - no big deal. Being the first to diagnosis big things, that's exciting. I wouldn't have that experience and have been able to grow in more areas [if I weren't in this clinic].*

Finally, the licensed acupuncturist mentioned how satisfying it can be when she has been able to help people lessen their dependency on pharmaceuticals. She said, "Naturopathic doctors are conservative about prescribing pain medications and informing patients that they will be on them for the rest of their lives and they don't need to be. I love my role here as an acupuncturist when patients get off certain drugs."

Based on the successes observed through CNM's journey into becoming a PCPCH, other clinics may look forward to achieving similar successes. PCPCHs promote more access to naturopathic and integrative care while simultaneously reducing costs and limiting admissions to the emergency room. PCPCH providers have enriching professional experiences because they have access to a varied types of patient cases in these settings. Although there are many successful outcomes associated with working in a PCPCH environment, there are also a number of challenges and barriers to overcome. This next section explores some of the issues providers revealed during the interview process.

## Challenges

Providers identified a number of challenges in regard to working in a PCPCH, and specifically these challenges pertain to developing systems, having access to certain services and resources, and staffing and patient management.

Office managers identified possible structural challenges when transitioning to a PCPCH. One manager said that it has been difficult, "building a sustainable system and ensuring that everyone is well trained on the electronic health record system." She later explained that during the clinic expansion, staff assumed and absorbed many new tasks and responsibilities and were unable to "hire consultants to determine what was best" due to financial constraints. This meant that there was a lot of trial and error in determining the appropriate and most effective means to accomplish specific tasks. Another manager talked about the problems the clinic encountered when they had to hire additional staff to support the growth of the clinic. She said,

*Staffing was a challenging. Everyone was new to us. The billing department was not sure what was being reimbursed and why. And there were problems with CareOregon regarding the on and off coverage of Acupuncture. [Another challenge we faced was that we went from seeing patients that were typically healthy to patients in need of more management. [But perhaps the] biggest challenge was spending time with patients who are in poverty and can't afford their supplements.*

A number of challenges also emerged around access to certain services and resources. One provider described the impact of the lack of mental health services by saying, "Mental health is HUGE – there are so many patients who need mental health. They come in and are a complete mess and we don't have any resources for them. [To address this, we] put in a grant for a mental health provider." Another provider identified challenges associated with hospital admissions. He said,

*The number one challenge at this point is that we don't have rights to admit to a hospital. It is an extra hurdle to get in touch with another provider and relay situation to get person, explain to the person and have them do it on their behalf. Typically it works out well, but sometimes had to have someone go to emergency room, mostly acute situations, and wait to get the care they need. When what they need is a pulmonologist. [It is very] frustrating for the patient.*

Lastly, a recent graduate articulated some challenges around patient management by saying,

*All of the challenges coming out of school, realizing we are seeing patients with a different genre of patients that we had to manage effectively with our naturopathic lens. I spend so much time with patients and that is where we excel with nutrition counseling. It is always evolving. We just had a provider meeting where we talked about difficult patients. Patients who are on benzos and heavy narcotics...a lot of those who get assigned to us are already on these and we have to manage them. We don't come out of school knowing how to manage them.*

For clinics wishing to becoming a PCPCH, CNM has identified a number of challenges and pitfalls that may lie ahead. Developing relationships with mentors or other clinics may be extremely valuable to help determine the best strategies to employ for developing your PCPCH. Beware of the demand for unseen services and how to collaborate with local hospitals. Staff may need to learn new how to manage pharmacologically dependent patients as well as how to attend to acute patients.



## **Conclusion & Future Directions**

In context of the changing health care landscape, the integrative professions are playing a pivotal role in reducing health care costs and enhancing patient experience through their involvement in PCMHs and PCPCHs. The PCMH and PCPCH models are improving health care by restructuring how primary care is organized and delivered. We are grateful for CNM's important contributions to this report as health care providers look to the leaders of integrative medicine to provide information on how to successfully create integrative PCMHs. By exploring the early adopters such as CNM, we can begin to identify the best practices, strengths and weaknesses of these models, and share this knowledge with others to advance all the integrative professions.

While this is indeed a noble beginning, there is still much to be learned about the leadership, organization, and education supporting successful IPCMHs. This exploratory report leads us to frame a number of questions for future study. Namely, are there types or qualities of successful leaders who serve as heads of IPCMHs? How does the concept of integration truly operate in these contexts? What are the skills, behaviors and competencies of successful practitioners found in IPCMHs? How are underserved populations and community health addressed? And lastly, how does the achievement of Triple Aim goals further advance and promote the integrative professions? We, at the Academic Collaborative for Integrative Health, look forward to continuing this inquiry and to share these findings with our constituents and stakeholders.

## **Appendix A**

### **Interview Protocol**

- About me and project overview.
- Tell me about your clinic. How long have you worked there?
- Does your clinic have a special focus? (teaching, underserved focus, population health)
- What kind of patients do you routinely see and treat at the clinic?
- What role does integration play in your clinic? What are the practices around sharing patients, referrals, collaborating with others, etc.
- Tell me about using technology in this new environment? Was it a barrier to overcome? EHRs?
- How does your clinic promote and build a culture of data and accountability?
- What do you identify as the biggest challenges related to working in a PCMH/PCPCH environment?
- What do you identify as the biggest successes related to working in a PCMH/PCPCH?
- Do you feel that participating in a PCMH has changed your profession or discipline in any way? If so, how?
- What kind of quality measures does your clinic focus on?
- Do you have any reports or data that shows patient outcomes? Other metrics? Patient satisfaction surveys?
- What kind of training would you recommend for students or graduates that might wind up working in a PCMH someday?
- Is there anything else I should know about that I did ask?

## Appendix B

### Resources

[Patient Centered Primary Care Institute](#) - The PCPCI accelerates primary care transformation in Oregon by bringing together health care providers, clinic staff, technical experts, patients, quality improvement professional and others to share valuable knowledge and resources. The PCPCI offers webinars and works with clinics in a series of learning collaboratives focused on primary care home model implementation.

[The Oregon Health Authority PCPCH Program Recognition Criteria](#) - This lengthy document is an detailed overview of the PCPCH recognition criteria based on the recommendations of the PCPCH Standards Advisory Committee and input from various stakeholders across Oregon. The 10 Must Pass Criteria are included and are explained in great detail.

[The Oregon Health Authority PCPCH 2014-2015 Annual Report](#) - A sixty page document is a detailed overview of the PCPCH program in Oregon chronicling health care transformation in Oregon, PCPCH model of primary care delivery, PCPCH program functions, verification of standards and measures, PCPCH characteristics, program evaluation and future directions.

[Oregon's Coordinated Care Model](#) - A seven page document highlighting the six key elements comprising Oregon's Coordinated Care Model - Best practices to manage and coordinate care, Shared responsibility for health, Performance is measured, Paying for outcomes and health, Transparency and clear information, and Maintaining costs at a sustainable rate of growth.

[Oregon's Health System Transformation CCO Metrics 2015 Final Report](#) - A comprehensive report that shows the progress of Oregon's coordinated care organizations n quality measures in 2015.