Integrative Patient-Centered Medical Homes: A Profile of National University of Natural Medicine (NUNM)

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as part of The Project for Integrative Health and the Triple Aim (PIHTA)

Sponsored by

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

March 16, 2017

INTRODUCTION

This document represents the second 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 (LAcs)- will play a pivotal role in reducing health care costs, enhancing patient experience, and improving health care (Triple Aim) outcomes as well as creating 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)[1]. Although care in this model has been structured around primary care physicians, a few unique new models within the PCMH framework are beginning to evolve that include IHPs as primary care providers[2]. Models like the 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[3].

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[1] Adopted from https://pcmh.ahrq.gov/page/defining-pcmh

[2] In 2016, the National Center for Integrative Primary Healthcare at the University of Arizona has included naturopathic doctors, chiropractors, and acupuncturists as primary healthcare providers.

[3] Goldstein, Michael, and John Weeks. Meeting the Nation's Primary Care Needs. Rep. Seattle: Academic Collaborative for Integrative Health, 2013. Print

Table. 1 Attributes 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.
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 of physician-led PCMHs assumes that MDs have an intricate understanding of the values and practices needed to transform our fractionated, disease-based health care system to one that is organized around the principles of health and wellness. With at least 75% of our 3.8 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[4]. Logically, it makes sense is to incorporate systems, disciplines, and professionals that already have the knowledge, skills and training to focus on disease prevention and cultivating health. IHPs excel in promoting a culture of health because they undergo in-depth training focused on wellness and prevention, and use a less invasive approach if possible 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. Furthermore, IHPs impact patient populations through lifestyle and behavior strategies, yet these contributions have been under-represented in research, funding and scholarship.

[4] www.forbes.com/sites/danmunro/2014/02/02/annual-u-s-healthcare-spending-hits-3-8-trillion/#44dc9dca313d

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 Patient-Centered Medical Home, 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 (For more information on this topic, refer to the link in the Appendix). Due to the collaborative nature ACIH has with clinics on this list, 3 were selected for investigation: The Center for Natural Medicine, The National University for Natural Medicine, and Mountain View Natural Medicine. 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 working in 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 an overview of the issues and successes practitioners identified at the National University for Natural Medicine (NUNM) located in Portland, Oregon.

Methods

Due to the exploratory nature of this project, qualitative methods were employed 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 and 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 comprising 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 proposed as potential respondents.

As a result of the factors articulated above, 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, and 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 five providers including the chief medical officer, naturopathic doctors, managers and administrative staff were interviewed at NUNM for this project. Interviews were conducted over the phone with staff and practitioners during the months of September-December 2015 and on average lasted between 30-60 minutes. In some occasions, 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 which are 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 NUNM

The National University of Natural Medicine (NUMN) located in Portland, Oregon offers graduate and professional degrees in naturopathic medicine, Oriental medicine, nutrition, global health, research in integrative medicine, and integrative mental health. Formerly known as the National College of Natural Medicine, the institution became a university in the fall of 2015 after receiving approval to offer undergraduate degrees. In addition to granting undergraduate, graduate and professional degrees, NUNM is also home of the Helfgott Research Institute which specializes in conducting research on natural medicine and the art and science of healing. The university also offers both on and offsite residency programs and additional clinical opportunities are provided through its teaching clinics that offer integrative primary care and natural healthcare to diverse patient populations.

The teaching clinic at NUNM achieved PCPCH status in 2015 and was recognized is as a Tier 3 PCPCH (Text Box 1)[5] in 2015. The clinics at NUNM offer of full range of primary care services including immunization services for children and adults, STD testing and treatment, women's health, and testing for heavy metal exposure while offering an applied learning environment for residents and naturopathic physicians in training. Naturopathic doctors working at the NUNM clinic are trained as family and general practitioners and may have a specialty or focus in one or more of the following areas including: Anthroposophically-oriented medicine, colposcopy, drainage therapy, environmental medicine, gastroenterology, geriatrics, herbal medicine, homeopathy, hormone balance, integrative skin care/aesthetic medicine, IV Therapy, men's health, minor surgery, naturopathic/Chinese medicine integration, neurofeedback/biofeedback, pediatrics, physical medicine, sports medicine, small intestinal bacterial overgrowth (SIBO), transgender medicine, weight management/weight loss, and women's health. NUNM is committed to patient-centered care and launched a Compassionate Care Program that covers the cost of services to increase accessibility for those patients who do not have insurance. NUNM also houses a medicinary as part of the NUNM system of health clinics which offers a wide-ranging selection of supplements, herbs, homeopathic remedies, and tinctures. The medicinary serves providers, students and patients of the clinic as well as external providers and customers.

[5] https://nunmhealthcenters.com/an-oha-patient-centered-primary-care-home/

Text box 1
NUNM is an Oregon Health Authority A Top-Tier Patient-Centered Primary Care Home

*The Oregon Health Authority now recognizes the NUNM Health Centers as a Tier 3 Patient-Centered Primary Care Home—**the highest level of healthcare certification granted by the OHA.***

***What does that mean for NUNM Health Center patients? A PCPCH is the "gold standard of care." NUNM Health Centers** is now recognized for its commitment to providing high-quality, patient-centered care by promoting better coordination of care and clinical teamwork, and a better understanding of the patient's overall healthcare needs. Primary care homes reduce costs and improve care by focusing on preventive care, wellness and management of chronic conditions.*

***Patients a have access to a team of providers and students** who will use their combined knowledge and experience to best support each individual. The NUNM Health Centers healthcare team consists of a naturopathic primary care physician (PCP) and a team of NUNM NDs and licensed acupuncturists and Chinese medicine practitioners—all familiar with patients' specific treatment programs and needs. The practitioners at NUNM Health Centers are recognized for their professional expertise in assessing the root cause of imbalance in the human body—and in the treatments that work with the body's inherent healing abilities.*

Becoming a PCPCH

Deciding to become a PCPCH clinic at NUNM was a natural extension of its educational mission, scope and purpose. When I asked the Chief Medical Officer (CMO) why NUNM decided to be a PCPCH she simply replied,

Because in Oregon we can! I would say it was the belief that the clinic had sort of been operating under the auspices of education when I started there. There was less patient-centered care, but it had the potential to be a different creature. NUNM set the baseline from what was expected from a naturopathic medical school. In Oregon we have a large scope of practice and insurance so it seemed like a no-brainer and that as an educational leader that it was incumbent on us to lead the way to fill that gap.

Providers gave some insight about the practicalities involved with becoming a PCPCH and had mixed reviews. One provider explained that electronic health records (EHRs) are a more effective way to do medicine by saying, "Some doctors were reluctant to switch to an EHR and preferred the paper version of charting. But, I feel EHRs are a better way to do medicine. Tools are all there to order things and codes are easily accessible for billing." Other respondents acknowledged that there was some trepidation over converting from a paper system to an EHR. Below one provider describes the impact of the changing environment by staying,

It has been recent, that we have received PCPCH status in the last year. For me, I always had my own systems and practices w/in the clinic, so it has been a process of changing my systems. Referrals and using an EMR and that was a huge thing starting that in 2011. That was a lot to change from paper charts. Learning to do referrals through a computer and learning to order things thru the computer. Just different, not bad or good. Takes a while to get used to it.

She later talked about the processes involved with being a primary care provider in a PCPCH environment and the time needed to maintain communication with patients. She said, "If I don't look at my in-basket in EPIC every day, I will have over 100 messages from patients. It is a lot of work to go through those. Looking at all of those things requires a lot of work." Another confirmed this idea by saying,

I always have thought of myself as primary care provider. Although that sounds good on paper, there is a lot of tedious paper work and having very little time to focus on giving patients other options. In some ways, I feel I have become a glorified secretary. It has made us refer patients around, but it also seems to make more sense. We are communicating with other providers and are keeping up with blood tests….Feels like down the road it will be more paperwork.

Lastly, another provider hinted that there was not much of shift for the clinic at NUNM to transition to a PCPCH. She said, "Things aren't really changing that much, we were doing that stuff before. How PCPCHs are structured, we are different. We don't have medical assistants, but our students serve as physician assistants. We are molding our staff around that model and have done that well."

Advice

Building an effective PCPCH environment goes well beyond the typical roles and responsibilities associated with working in integrative clinics. When asked to provide advice for students or practitioners wanting to work in a PCPCH setting, respondents conveyed three main ideas: the need for specific training, the value of being adaptable, and the importance of evaluating the field of naturopathic medicine prior to selecting it as a career. One respondent discussed the importance of due diligence and preparation prior to becoming a PCPCH and stressed the benefit of having flexible and adaptable staff when confronting change. She also acknowledged that resistance sometimes accompanies the process of becoming a PCPCH by saying,

I would say that I think based on how things moved for us in our clinic, that having upfront preparation is important. We have to interface and assess how we work with referrals, vaccines, and health maintenance. We received training over the last 2 years to really work on it and develop and enhance these processes over time and we eventually received PCPCH status. Be ready for lots of change and recognize that some people won't want to do it. I think that all of us who are there have always been willing to roll with the punches.

Often, changes may be facilitated by someone who has previous experience in primary care. The ability to build bridges between conventional and integrative healthcare professions is made possible through collaborative and ongoing relationships, or even in the way academic programs are structured. NUNM hired a Director of Clinical Operations who came equipped with 20 years of experience in the medical field and held a range of positions from information technology to billing to clinic manager. Interestingly, she left her previous position because she felt her role was not actually making health accessible and had a strong yearning to find a place where she could contribute more to community health. As a result of this willingness and desire, she was an ideal candidate for NUMN, well suited to build bridges.

My role is problem solver by nature and I created new processes to help things run smoothly [when I first started at NUNM]. They were still doing a lot of paper processes when I got here. They just started taking insurance a month before I came on, so I had a lot of knowledge about how to do all of that - negotiating contacts, billing manager, front desk, clinic manager, I was a floater - I have done every aspect of a health center so I can give you knowledge in whatever you need. I do anything operational that happens at the health center. I am also the supervisor for all health staff and I handle front desk issues, patient issues, etc. It is a very broad position and I am really in the jack of all trades position here. I handle lab changes and medicinal changes and I keep everything running smoothly.

Although background and training in conventional medicine helps to develop and enhance systems and processes in existing PCPCHs, other providers identified a need for more in-patient experience as well as training on insurance and coding. According to this naturopathic physician,

We need more in-patient training. The worst cases are the ones you need to know whether or not to refer. If you haven't seen 20-30 patients with advanced pneumonia, you won't know what to do. Having a depth of experience is very important. Our program mimics traditional medicine programs, and although it is written that we should incorporate naturopathic approaches, there is an emphasis on conventional medicine approaches.

As mentioned above, building bridges between integrative and conventional healthcare may also be supported by the manner in which academic programs are designed.

And another added,

The biggest recommendation I have is that I really wish that medical schools would include how to bill and code because that is such a huge aspect of our work. You need to have that knowledge and learning it before graduating helps prevent us from having to teach it later on. We would have a lot less struggles because it is hard to reach and teach everyone these concepts when they are serving patients.

Lastly, one naturopathic physician insinuated that prospective students of naturopathic medicine should contemplate the career trajectory of naturopathic physicians in the current era of healthcare, including the realities of working in a PCPCH structure, prior to acquiring a degree in this field. Because NUNM is also a teaching clinic, noting themes pertaining to educational trajectories of students does merit inclusion in this paper, even though they seemly diverge somewhat from the topic of PCPCH structures. The PCMH structure, however, is indeed part of the changing healthcare landscape and growing pains are a natural consequence as part of this process and evolution. It is evident that the provider below finds great value in the field of naturopathic medicine, but pragmatically wrestles with the fact that it might be challenging for graduates to pay off loans and make a living in the context of the changing health care landscape.

I think NDs are needed and a whole systems approach is needed, but the current climate being an ND in the US is very challenging. The money being paid for a ND program is kind of absurd when the income earning capacity is limited.

For graduates wishing to work in or administrators thinking about becoming a PCPCH, it is advised that both groups prepare as much as possible before making any changes. Time is an ally for creating a shift in culture and it is important to recognize that it is natural for some providers to resist the idea of becoming a PCPCH along with all of the bureaucratic challenges that accompany it. To create buy-in and acceptance, it may be useful to develop strategies for effective leadership, engage in strategic planning, and partake in consensus building activities prior to unveiling any plans to become a PCPCH. To better prepare graduates to work in these settings, institutes that train and prepare naturopathic physicians should consider enhancing educational opportunities by offering more in-patient training and also equipping students with the requisite skills on how to properly bill and code. Finally, decision makers might consider employing political strategies to further professionalize and advance the fields of acupuncture and Oriental medicine, chiropractic, and naturopathic medicine in order to create more job opportunities for the next generation of providers.

Data

Providing care in an IPCMH is quite different than providing care in an integrative clinic due to the strong reliance on data to ensure continuity of care and monitor population health. Tracking patients' health status along with needed treatments requires a tremendous amount of time, effort and coordination to

regularly assess whether or not each patient is receiving the care they need to satisfy targeted quality measures. Each clinic must develop the capacity to work with data and individuals need to cultivate the ability to not only interpret data, but also respond to what is needed in terms of patient care. Working with data is a relatively new endeavor for most providers in health care, but it is somewhat more unusual for integrative providers who often do not have the financial support to obtain the needed technological resources.

When asked about building a culture of data at NUNM, respondents expressed frustrations with the electronic health record system (EHR), questioned the utility of quality measures, and noted that working with data produced a latent team building effect. Adapting to a new EHR takes time, and, as others have pointed out, there are a number of challenges associated with it. Firstly, there are many different EHR systems and if a provider was trained on one system and later moves to a different clinic, he or she will likely need to learn a new EHR system. Time will be needed to for the provider to learn the new system, and it is often difficult to plan training for providers who spend most of their time caring for patients. Secondly, providers tend to prefer the first EHR they learned. As one provider explained, "In terms of barriers, this is my 5th EHR and I like the others I have used better. We are not part of EPIC system and there are several limitations [with the system we are using]. With doctors, trying to teach all of them a new billing processes is challenging because it is hard to get them all together in one space."

Another provider while talking about building a culture of data at NUNM, expressed some frustration that existing quality measures are not holistically aligned and do not capture or reflect systems thinking.

I have always worked with data and I have always looked at biomarkers as well that we are not measuring with conventional testing. I feel like I am correcting these with my patients, but there is no quality measure to address that because quality measures only focus on blood pressure, and it doesn't do justice to the whole systems piece. Patients feel like hell, but their blood pressure is better. Quality measures look at one tiny part of being human and this seems very dangerous to me. In the world of data, I am reprimanded if my patients have inflammatory measures that have gone down, but their LDL hasn't budged. On paper it is good, but it is not a reality. My interest is in building a bridge...as we get better biomarkers I think that will help because they can be better data points we can collect. Now we take one measure and relate that to the entire person.

Another provider talked at length about the benefit of using data to track outcomes because the profession of naturopathic medicine has been charged at times with having a lack of evidence to demonstrate the effectiveness of the profession. She explained,

I think the important thing is to keep focusing on patient outcomes. It is easy for our profession to be pulled down by the claims that we don't have data to demonstrate what we do. It is easy to say there is no proof. I want data because data speaks when opinions don't matter. I have data that shows what I do works, and if I don't then I should stop doing it.

Contrary to her colleague's advice, she later explained the necessity of using existing quality measures as opposed to devising new ones.

We need to continue to use standardized measures and we don't need to try to create different measures. If I am not moving that needle, then I need to change what I am doing to show that it works. My goal is to make sure that the 67 year-old diabetic patient who doesn't want meds can control her diabetes through diet and exercise through Pokémon Go, and we are encouraging her to do it because her numbers are improving. Those are the kinds of

stories that will eventually compile to move the needle and if we are not available then they can only do it through pharmaceutical medicine.

Lastly, although one provider noted some incongruence using quality measures to measure a system of naturopathic health, another discovered that building a culture of data produced a sense of community and collegiality among her peers and advisors. She said,

If we do the leg work, clinicians like using data. It feels like they are working together and you can feel the camaraderie between the teams. This falls away during summer time because we don't have team meetings. The other benefit in the quarterly reports to board of trustees, they are now aware that docs are doing this and they have developed curiosity around it as well. It is understood that doctors are working in a different way than they used to before.

Overall, building a culture of data can foster a sense of community and collaboration among providers. It should be noted that using new tools and systems will undoubtedly require time to develop proficiency and that quality measures by themselves are not necessarily in alignment with the spirit of naturopathic medicine.

A Changing Culture

As described in the previous section, learning how to operate in a PCPCH environment may be somewhat of a cultural shift because providers are learning how to weave data-driven practices into their daily routines and systems. This section touches on how these changes were introduced to providers to orient them to this new and sometimes overwhelming world of quality measures. Since NUNM is also a teaching clinic, how these changes interface with education will also be discussed.

To set the tone and expectation for working with quality measures, the CMO recognized that providers needed time to orient and adjust to the culture of quality. She explained, "At first, I tried to get our providers acclimated to the quality culture because it is not native to us. We are also doing a curriculum revision to support this and we are essentially driving towards benchmarks, by setting a baseline or expectation that we will improve a certain measure in some way." In addition to incorporating quality elements into the curriculum, staff and providers learn through ongoing clinical and faculty meetings that are held monthly. According to one provider, "Things are discussed during these meetings and ideas are also exchanged over emails and trainings. And the CMO is always there to answer questions. But when it comes down to actually doing it, it can be really difficult. I am not a tech person and I ask her for help, so there is ongoing support that way."

Other providers shared similar frustrations with adopting new data-driven practices. The CMO said, "There is one doctor who reports feeling overwhelmed by these changes. The database exhausts her because the result is an elevated expectation of performance." Another provider talked about the layers of bureaucracy piled on top of student learning as a result of working with data. She said,

I am not sure how everyone felt exactly. It was hard. It was different. A lot of us feel - there are so many things we have to do now. All the health care maintenance we have to go through with patients and update it in the chart and it is a very good practice, but it is just when you are doing a teaching clinic, it just takes up a lot of time.

In sum, adjusting to the world of quality measures requires some careful planning and oversight. Having leadership recognize that the organization it is indeed undergoing a cultural transformation may help providers ease more gracefully into the world of data-driven care. Some providers will undoubtedly find

the changes overwhelming and others may simply label them as time consuming. Employing a team-based approach where guidance and help is easily accessible is not only practical, but it is consistent with the collaborative approach to the structural orientation of PCPCHs.

Education

As mentioned in the introduction, NUNM recently achieved university status and expanded its educational opportunities by adding undergraduate programs in nutrition and integrative health sciences in the fall of 2015. The university offers a robust residency programs for naturopathic and acupuncture and Oriental medicine and also helps clinics develop offsite residency programs in other states. The clinics at NUMN are designed to provide clinical experiences in primary care, and full-time residencies are available for first, second and third year students of naturopathic medicine.

Administrators at the NUNM clinics not only have to be cognizant of the educational components of the residency program, but they have added administrative responsibilities since these clinics are also PCPCHs. While this is undeniably more work for the teaching clinic, it does provide valuable pedagogical opportunities for residents since they are learning the nuts and bolts of providing accountable primary care.

The curriculum for the teaching clinics at NUNM is an applied, hands-on approach and is attuned with population health. One provider gave an overview of the curriculum by saying,

Some of it (the curriculum) has to do with making sure students have a lot of hands-on time with the database; how to access it, find what they are responsible for, and how to complete the associated tasks. We are starting to teach a more integrative care model where you are expected to work with a medical assistant, for doing thing like filling a prescription for example. The work flow resembles a conventional medical practice and we are cognizant of how it enhances the Triple Aim. Our students see that more people are receiving health care and we are saving money. We see the impact on the population and community health perspective.

Another provider shared that the educational structure of naturopathic medicine is changing to resemble the curricular framework found in conventional medical schools.

In the curriculum we went from individual classes to block classes which is what the allopathic schools have. The first year covers all of the sciences and pathologies. The second year is the reproductive block and students learn everything about reproductive health for men and women including an introduction to childbirth. We teach all of the botanicals, nutrition, etc. and how to treat and manage conditions, diagnosis, etc. Students will learn work that is based on cases and labs to how to integrate what they are learning in class into a clinical setting. I feel it is more of a holistic way of teaching.

While the teaching methods are indeed more holistically structured, another provider remarked that the educational evolution at NUNM is drastically different from training that occurred 20 years ago. This provider lamented, "The change in the profession has been huge and it is also changing in the general curriculum as well." Although this may be disheartening for some to feel the profession is changing, others feel this is a modernizing and progressive step for naturopathic medicine to embrace the future of healthcare.

Although the teaching clinics at NUNM resemble conventional clinics in terms of structure, they operate quite differently and often devise creative solutions to solve problems. For example, most PCPCHs have numerous medical assistants on staff to help with charting and other administrative responsibilities. As

one provider noted, "Without a medical assistant it is difficult to do all of the paperwork required to be a PCPCH. We can't afford to hire an MA so we are using 3rd year medical students as a solution. We have always been efficient and creative with resources."

There are other challenges for operating a successful teaching clinic that is also part of a PCPCH network. Inherently trained in patient-centeredness, naturopathic doctors treat patients as individuals; this implies that while two patients may see the same provider for the same disease or condition, they might receive a different treatment plan based on their unique overall health or lifestyle. Because naturopathic doctors spend more time with patients than their conventional counterparts, they have the ability to carefully select a treatment option from a vast array of tools instead of choosing a one-size-fits all approach. In a PCPCH environment, the challenge is how to create adequate time and space for individualized treatment. One provider explained,

One of the biggest challenges we have at the teaching clinic is consistency. We need to make patient experience consistent in terms of paperwork, exams, and scheduling. We also need to make sure there is not too much variety in things that should be standardized, but to allow for individualized treatment that occurs from patient to patient.

Another important element to consider when converting a teaching clinic to a PCPCH is the time needed to cultivate buy-in from all of the faculty and staff that will be involved in the conversion. Becoming a PCPCH is quite an undertaking, and without a supportive organizational structure in place the challenge would be even more daunting. The same provider above added, "You have to make sure that you sequester time for buy-in. It is also important to sit down on a regular basis to continue to educate and train providers because they have to understand the nuances in regard to how the clinic works." Education is continually needed on billing and coding procedures and there are a number of strategies NUNM uses to ensure providers develop these skills.

We published laminated guides describing billing and coding procedures and make them readily available. I spoke at clinic orientation, at grand rounds, residents' training, and again at clinical faculty meetings. I am also using some of the patient care money we received to improve physician awareness on charting procedures and we are also doing trainings with a coding specialist. I would love to hire someone to do that, but a part of me thinks it is important that doctors and students know how to do it correctly all by themselves.

In sum, it is recommended that teaching clinics interested in becoming a PCPCH familiarize themselves with the amount of time needed to prepare faculty and staff for such a transition and it is wise to earn support for this decision prior to making the change. It may also be challenging to strike a balance between providing individualized care while attending to standard processes that comprise the PCPCH framework. While the PCPCH structure may seem foreign at first, creative solutions can be found internally for staffing or other administrative needs. Changing to a PCPCH structure adds tremendous value to an educational setting because it gives students a hands-on opportunity to learn about population health management while simultaneously helping the profession advance through the creation of more primary care providers.

Challenges

Medical home models are simply ways of organizing or arranging care and the framework is in fact very much in alignment with the values and practices of naturopathic medicine. Working as a primary care provider in addition to working in an organized care environment are likely new experiences for naturopathic doctors working in a PCPCH setting. During the interview process, respondents were asked

to identify some of the specific challenges associated with working in a PCPCH environment. Some providers were very clear about the distinct challenges that exist while working in a PCPCH while others were adamant about the fact that some of the challenges were related to serving as a primary care provider. In retrospect, it may have been difficult for providers to tease out the nuances between the challenges that arose as a result of the PCPCH framework versus the challenges associated with doing primary care. Nevertheless, providers identified some perceived challenges associated with both of these practices.

Finding suitable substitutes for naturopathic doctors when they take leave for illness or vacation is one challenge that emerged during interviews with providers at NUNM. As one naturopathic doctor explained, "We have all these NDs, but they all practice so differently and it is hard to know which ones treat more like me when I go on vacation. I feel that goes back to philosophy, standard of care beyond allopathic standards of care. There is no serious discussion about that." The respondent's comments above may have the most impact on the patient experience. While it is truly beneficial that patients have access to individualized care, they likely are accustomed to the way in which their primary care provider handles each case and therefore might be sensitive to the ways other naturopathic doctors deliver care. The issue has more to do with the maintaining the continuum of care than the manner in which naturopathic doctors practice medicine.

Another challenge pertains to communication. NUNM engages in a logistical practice they call, Share the Care, which means that every member of the staff is expected to support a patient's experience from the moment they enter the building to booking their next appointment. Scheduling, rooming, doing the patient encounter, and checking out the patient are all elements of the continuum of care and contribute to the totality of a patient's experience. This practice is centered on sound communication where team members are constantly exchanging information with providers they need to deliver the best care possible. While Share the Care concept is well intended, there are some pragmatic challenges associated with administering this practice. For example, "Our scheduling staff doesn't get to talk to doctors as much as they should. And so there are some glitches to overcome. Medical records may not pass a note to doctor to let them know the labs are in. The way we want to work is to hire a medical assistant to be the go between. We don't have it yet," explained one provider. To address this challenge, staff at NUNM are currently using a resident to fill the role of the medical assistant.

Lastly, another provider hinted at a possible values clash for naturopathic doctors working in primary care and described how education and training for naturopathic students is changing. As mentioned above, this might have more to do with naturopathic doctors serving in primary care roles than specific challenges associated with the PCPCH structure. The following section will describe in more detail how the PCPCH structure naturally supports the values and practices of naturopathic medicine. Yet, one provider highlights tensions between preferred naturopathic treatments and the influence of pharmacology.

The new model is for a primary care provider environment. ZoomCare graduates working in these environments are making six figures and all they do is see acute care patients giving antibiotics. Grads don't know how to put together remedies for patients. Schools set the tone and there is a push to consult current standards of care and then come up with something naturopathically. The emphasis is placed on pharmacology and there is less understanding of ND approaches.

Overall, some of the possible obstacles to consider prior to becoming a PCPCH involve being sensitive to substitute staffing needs and finding opportunities to enhance communication. Additionally, while

many providers have noted that the naturopathic profession is indeed in flux, more about this metamorphosis will be described in an upcoming section. Given the anticipated primary care shortage along with the fact that the future of medicine involves the medical home model, naturopathic medicine is well positioned to advance the profession if providers are able to find a ways to remain true to their values and practices in this new era of healthcare.

Collaboration and Integration

PCMHs are closely aligned with the values of integrative health and medicine as they represent a comprehensive, collaborative, team-based approach to care while simultaneously focusing on accessibility and coordinated services. Naturopathic doctors are well suited to work in PCPCH environments because they empower patients to be in charge of their own healing processes. Furthermore, naturopathic care is collaborative in nature, taking into account family and patient preferences, while it also exemplifies whole-patient and individualized care. Naturopathic doctors promote health and wellness by emphasizing prevention and favor non-invasive therapies that are both safe and effective. All of these values and practices indeed complement the structure of a PCPCH (Table 1). One of the main attributes of the medical home model, comprehensive care, requires various types of providers working collaboratively on a team to support patients' physical and mental health. In the IPCMH model, naturopathic doctors work not only with nurses and other medical specialists, they also confer and collaborate with integrative providers including chiropractors and acupuncturists. For this reason, collaboration and integration are therefore central features of this model. In this section, providers reveal how interprofessional collaboration occurs at NUNM through team dynamics and developmental support. The politics related to integration will also be discussed.

The clinic at NUNM is comprised of several sets of teams responsible for a specific block of empanelled, or assigned, patients. Teams are structured to have access to other integrative health providers. As one administrator explained,

We have pulled a chiropractor on to many of the teams and now four out of our five teams has one on their team. The other team has a physical therapist as a member. We have not yet divvyed up acupuncturists and put them on teams and we have left them as a specialists to be used as needed. In terms of referrals, we are conscious not to violate Stark law, which basically means that a physician can't make a patient go to a specific provider. In terms of internal referral, our site specialist doubles as data analyst and she started a preference list for us in our database. This has streamlined work flow and it lists all of our internal referrals in-house. We are able to refer to chiropractors, acupuncture, spirometry, EKG, counseling, minor surgery, colonics, cardiovascular health, homeopathy, hydrotherapy, IV therapy, minor surgery, physical medicine, SIBO analysis, and women's health.

One of the main practices related to team-based care in a PCPCH structure is following how the clinic and providers impact the clinic's quality measures. Ongoing data collection is needed to regularly track quality measure benchmarks and to inform providers about their progress in meeting these goals. The NUNM approach to gathering this information is a blend of ongoing professional development and team building skills. The administration uses a portion of regularly scheduled staff meetings to examine one issue or quality measure at a time and brainstorms with providers to see how they might be improved. Instead of a top-down approach, this peer based strategy gives providers an opportunity to have ownership and a stake in the administrative decisions being made at the clinic.

In order to discuss patients within teams we use a project manager, and in other locations this position would be called a data analyst. Our project manager pulls a dashboard report on a monthly basis capturing quality information for a given month. Doing this on a team basis was quite unusual since most clinics pull data by

individual docs. Data analysts makes graphs and compare the findings to the previous month. For example, we look at the percentage of patients who have completed a quality measure alert for blood pressure. We bring the results to a faculty meeting and hand them out. Prior to meeting, the CMO goes through trends and highlights areas that need a little nudging, and if our colonoscopy numbers are low, maybe we send out a batch letter - not an edict, but what could your team do to move the needle on that specific variable.

The ability to utilize different types of providers is both a function of having a strong administrative core and excellent communication skills. As the Director of Clinical Operations explained, "To make integration happen, as a referral coordinator, we needed to find out what is covered with insurance. We have a lot of barriers with insurance. So we have to make sure patients get the appropriate referrals." As mentioned above, communication between providers using the Share the Care concept influences both patient experience and patient satisfaction. Although communication is a requisite ingredient for any integrative model, communication at NUNM is a conscious and deliberate endeavor to facilitate work flow and to also build community. The Director of Operations saw an opportunity to enhance communication efforts that were limited due to the building's architecture. She explained,

There is a large separation since we are a 2 story clinic, so it was hard to communicate in the past. My goal coming on board was to improve communication. I wanted to create the sense that the downstairs staff is here to support the naturopathic doctors and we wanted them to know that they could count on us to be helpful and do things to bridge the gap and make their work load easier.

She later explained how these communication patterns were established by saying,

I emailed the staff to let them know. Because we have so many doctors here, getting them together on the same day and time was impossible. We do have residents assigned to work each and every shift. It was just a matter of going to that meeting at the beginning at each term to get the message out during that shift. Face time and one on one time for five minutes was the most effective.

In terms of collaborating with other clinics outside of the NUNM network, the clinic received developmental support from the Oregon Health Authority to integrate clinical best practices from other PCPCHs. In this sense, integration and collaboration occur not only among providers, but among clinics as well. As the CMO explained,

The Oregon Health Authority provided some learning collaborative grants with different areas of funding (i.e., improving access) and we joined in with 5 other clinics trying to improve access to care by deciding how to manifest improved access to care. We worked with Care Oregon, one of the larger payers in the state, and they provided consultants and coaches who facilitated monthly training and onsite learning collaboratives to learn from other clinics' best practices. NUNM was the only integrative clinic that was included with the rest of them and were told we were making progress and our college model was inherently different than other models.

Political factors sometimes influence team dynamics in regard to integration and collaboration. NUNM strives to have different types of providers represented on each team, but for some disciplines, scope of practice can limit what services and treatments are performed in relation to naturopathic care. The Director of Clinical Operations explained,

Some of the integration, especially with chiropractors - they are only allowed to operate in the realm of what chiropractors can do within scope of what naturopathic doctors can do - such as spinal manipulations and massage techniques. Patients get referred to other providers for women's health services. And naturopathic doctors refer to licensed acupuncturists for pain. We try to have a practitioner on each care team to have a balance so that you can get all of the services you need on one team.

Policies and regulation also impacts naturopathic care. The CMO was recently at a conference and it became clear that IUDs were not included within their contract with an insurance company even though they are within the scope of naturopathic practice. As a result, insurance companies are now in the process of rewriting the contract to cover IUDs, but until the contract is finalized, it affects patient care. While NUNM was waiting for the contract to be rewritten, patients were unable to obtain the coverage or the services they need.

In conclusion, the values and practices of naturopathic care are naturally aligned with the structure of PCPCHs. NUNM fosters a collaborative, team-base approach to care and bolsters community by using staff meetings to develop internal capacity on how to use data to meet quality measures. The processes to support integration require a strong administrative core to tackle problems and to contend with any issues pertaining to insurance. Policies and state regulation may impact integration and may even on occasion limit providers' scope of practice.

Leadership

Although providers were not asked to share perceptions about management, the topic of leadership surfaced several times during conversations with staff at NUNM. Specifically, providers gave several examples of empowered leadership which is defined by leaders who are focused on professional development, who shape the intention, spirit and direction of collaboration, who respect individuals' rights, ideas and preferences, and who are quick to become involved when problems arise. As an example, the practice of administering vaccinations can be a contentious issue in the field of naturopathic medicine. Recognizing this issue, leadership at NUNM found a way to honor providers' beliefs and preferences for the practice and administration of vaccinations. One naturopathic doctor explained,

One of the quality measures the clinic as a whole focuses on is vaccinations. Regina sent out a poll to see who was interested in giving vaccines so we could or could not elect to do them on our shift. She is good that way and is very communicative and I definitely appreciate it. Everyone said yes but me. Most everyone is really comfortable doing them so it is really great that I have an option.

The above example demonstrates leadership's capacity to allow individuals to remain true to their values and beliefs while contributing to individuals' sense of agency. By using this strategy, providers feel empowered because they have a voice and a stake in daily operations. This approach is also consistent in the team work providers do together on quality measures. Another added, "At NUNM, primary care provider teams are put together. The various teams meet and decide what measure they want to work on (BMI, hypertension, hemoglobin A1C), and then at meetings each team looks to see how we are meeting each of the measures. We choose things and we work on all of them." Allowing providers to have a vested interest in specific measures ensures that work will be executed with greater interest and passion.

Overall, effective leadership sets the tone and direction of any clinic or organization and effective leaders model the types behaviors and skills they hope to instill in those around them. According to staff at NUNM, leaders who are admired and respected are ones who are always ready, willing and able to work shoulder to shoulder with any member of their team. As one provider shared, "People like [our leaders] are the backbone of the clinic. They are the type of people who are willing to step in and get their hands dirty. Regina is such a leader. She pioneers everything and models it all."

A Profession in Flux

There has been much debate in recent years at conferences and meetings about the status of the profession of naturopathic medicine and providers at NUNM articulated some of these issues as well. As providers expressed the joys and challenges of working in a PCPCH environment, many echoed sentiments that the field is in the midst of an identity crisis, while others confessed fears about how working as a primary care provider can sometimes can challenge the values of naturopathic medicine. Some argue that the medical home model is the future of medicine, and because of this reason, there are many naturopathic doctors who strongly feel that working as a primary care provider is a necessary step in the evolution of the professionalization of naturopathic medicine. Others, however experience these changes as growing pains while the profession adapts to this new era of healthcare.

The naturopathic profession has changed so much. Being a primary care provider is really different than being a naturopathic doctor. When I graduated, I felt I got to practice naturopathy and that was my role. I have always been integrative and I am very much a supporter of allopathic medicine. They are all my friends and I feel grateful for being able to refer patients to MDs, but now I feel like I have to do all of that. It is a burden to me and it is not the way I practice. I am not interested in giving drugs or vaccines. That's not what I studied for so many years. Several years ago I had residents and one worked with me for 3 years. And said to me, "God, you are so naturopathic. You have such confidence in using herbs and diet and you use that before you go to drugs." I have comfort in knowing natural approaches really work and if they need a med, I give them a med. I thought about what she says is right. The training now is more along lines of primary care and being ok with medication management.

The perception another shared is that a paradigm clash is contributing to an identity crisis and presents challenges and obstacles for new graduates as they search for new jobs and opportunities.

My profession is in a crisis. We don't know what our identity is anymore. The modern naturopathic doctor is in a tremendous amount of debt looking for funding and opportunities. It is all about money. Natural approaches are fine on paper, but the bottom line is it doesn't make money. A lot of students get motivated but later get disillusioned by where the money is and where the jobs are. My profession has a lot of alternative ideas about physiology that are not really worked out and my profession is not taking up that work. I think we'll head down the same path as osteopaths.

One naturopathic doctor described how to stay true to the values and practices of naturopathic medicine while serving as a primary care provider in a medial home.

There is fear it [the PCPCH model] is changing the profession and we have discussed this a lot, and we have at the same time done a curriculum change for the block program at our school. And we just started it this year. I am a proponent. I use the full spectrum of everything without any judgment for what I am using. Some people feel if you prescribe a drug you are abandoning the values of naturopathic medicine. I don't feel that way. I don't have any issue with that personally. We have worked really hard to keep the values of naturopathy in our curriculum and we do that during our shifts too. Even with patients, if we prescribe an antibiotic, we also recommend diet changes and a probiotic and send them home with many more naturopathic treatments. All of us who have been there feel like we aren't losing values. When you say, drug, it stirs something up for people. I haven't changed a lot for the PCPCH, I do all of things we are supposed to do, but I continue to use homeopathy.

As this provider points out, the structure of a PCPCH is designed to support naturopathic medicine. A misconception exists among some that the medical home model stipulates that care must resemble conventional procedures and practices. The quote above confirms that naturopathic doctors have the ability to remain true to the values and practices of naturopathic medicine, while working within a

PCPCH structure. Medical homes are merely a method for organizing care, and naturopathic doctors are challenging the notion that care must be delivered solely in conventional terms.

Another provider shared a snapshot of an evolving profession by revealing impressions about the challenges of transitioning to being a primary care provider after being in the profession for so many years. It is anticipated that the next generation of naturopathic doctors currently being induced to the profession, might not struggle with the idea of serving as a primary care provider or adapting to the PCPCH structure since they are already introduced to these ideas while enrolled in school.

Before we were doing more adjunct care and now we are taught that we can do it all. NUNM is training grads to function as primary care practitioners and that is important because that is what we are referred to as in the state of Oregon. All of us have really gotten on board with that idea and with the PCMH model, we are embodying it even more. I see it as valuable in helping students learning how to be a primary care provider and that is super important. So, whether I have discomfort with certain things, I try to keep it out of it. It is important that I model using those things on my shift. I think this new generation will not have any issue with this. Not at all. It is hard to change things after doing things a certain way for so many years.

One respondent shared her ideas about the underlying apprehensions some providers were perceived to have over accepting a primary care or PCPCH structure. She said,

The biggest pushback I saw, and this is me coming from an allopathic environment, is that some NDs felt they were selling out because they acknowledged a difference between ND medicine and MD. It is a much different environment, but it really wasn't much of a transition. Nothing really changed because we were a PCP clinic before. The sentiment was that NDs feared they were becoming allopathic and adopting that type of personality and practice.

Another added,

I would say it [the profession] has changed for the better. It was at the AANP conference I recently attended where I became aware that the profession has a longer distance to go than I initially thought. We accept mantle of responsibility and we are teaching how being a PCPCH is done. NDs are licensed in 17 states, so there is a large population of naturopaths that this is not accessible [to the public]. This work needs to be scalable so that it can be applied to other settings.

Overall, it is undeniable that the field of naturopathic medicine is indeed changing with more and more providers serving as primary care providers. Although some providers are experiencing growing pains as a result of this transition, it is evident that the values of naturopathic medicine are able to stay intact within the PCPCH structure. Students currently enrolled in naturopathic programs will likely have an easier time adopting to the medical home structure given the fact that many of these ideas, concepts and practices are being introduced or modeled in educational settings.

Patient Centeredness

When asked about patient experience and patient centeredness at NUNM, providers emphasized a commitment to these practices when outlining the Share the Care concept described in a previous section. Conversations with providers also revealed much insight around the practicalities of attending to patient-centered care by knowing how and when to refer patients, the formal and informal ways

NUMN uses data they collect to improve overall care, and how the clinic offers culturally competent care. (Please refer to Text box 2[6] for an overview on patient-centered care at NUNM.)

Providers at NUNM refer patients to other providers based on patient request. One provider explains that referring patients is done, "when it is decided to be medically necessary, not responding to whatever therapies we are using." Patient experience at the teaching clinic at NUNM is a balance between understanding patients' existing needs and providing the right amount of education and motivational support to promote self-care. One naturopathic doctor expanded on this idea by saying, "Collectively, we meet patients where they are at and what they really need and want. We educate patients on vaccinations. They are not right or wrong, we need to educate the patients and deliver relevant information." Ensuring top-notch patient care also mean being deliberately aware of the different types of populations and groups a particular clinic is serving. The CMO illustrates this idea by saying,

Some of it has to do with having multiple different shift focuses. For example, we have a shift for trans-medicine. They follow best practices and do continuing education for working with that population. In this capacity, we address the needs of specific populations. Sometimes we work with translators and try to make the clinic welcoming to a broad array of patients. If we are unable see them we try to match them to a clinic that meets their needs.

Lastly, one hallmark of naturopathic care is extended office visits that not only enhance and nurture doctor-patient relationships, but also allot time for educating and encouraging patients to be active partners in their health care. Working in a PCPCH environment creates a logistical challenge for maintaining office visits of a length naturopathic doctors are accustomed to in order to deliver quality care in an efficient and timely manner. As an example, one provider said,

In an allopathic medicine, you have 7-15 minutes with patients. Our visits go between 30-60 minutes and that was a good model 30 years ago and I don't think it works very well anymore. I think our rotations are getting busier so we are having to be more efficient. [We have to] streamline what we are giving them. A 45 minute lecture on diet doesn't work anymore.

Text Box 2. Patient-Centeredness at NUNM

Patients at NUNM Health Centers are given a team of practitioners and students who corporately design an ideal health plan based on patients' needs, desires, and preferences. Patients and families benefit from the seasoned expertise of an attending faculty member, the recently gained knowledge of a resident and the enthusiasm and work ethic of a senior medical student. Patient wishes and desires are always held utmost in the process with a goal of focusing on their immediate concerns while keeping an eye on maximizing wellness.

Since learning and teaching are taking place along with caring for the patient, appointment times at can be one to two hours in length. Patients should plan accordingly to allow for a thorough analysis of their health and well-being.

At the first appointment, patients meet a team of providers – typically two students, an attending practitioner and sometimes a resident *physician. A patient's primary contact and communication will be with a "primary" or "intern," a senior naturopathic or Chinese medical intern. The intern will address current health concerns and as well as a patient's health history. He or she then confers with the supervising practitioner on the next steps – physical exam, further history, lab work, etc. The patient is offered information and choices during all phases of building a treatment plan for you.*

[6]Adopted from https://nunmhealthcenters.com/schedule-an-appointment/what-to-expect-at-our-teaching-clinics/

Formally, NUNM uses two tools to evaluate patient experience, patient satisfaction surveys and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The Agency for Healthcare Research and Quality (AHRQ) developed the CAHPS for patients and consumers to evaluate their experiences with healthcare in regard to quality. (For more information about CAHPS, follow the link in Appendix A). Specifically, these surveys cover topics including communication with health care professionals, access to care and information, customer service and coordination of care. Data collected from the CAHPS surveys helps clinics identify relative strengths and weaknesses in their performance, determine areas of needed improvement, and track and monitor progress over time. NUNM recently completed its second cycle of the CAHPS survey and results from the first year showed that over 70% of patients were happy with their care. Raw data for year two has only recently been released and NUNM is looking forward to seeing how the clinic has matured from year 1 to year 2.

Informally, NUNM engages in three other processes to enhance patient experience. Firstly, the Caught in the Act initiative, is a way to elicit positive and/or negative feedback from patients using comment cards on site at the clinic. Information gathered from the Caught in the Act initiative often brings areas that need attention into focus and enables the clinical administration to improve specific processes or systems. Secondly, the Compassionate Care Program helps uninsured patients and patients whose insurance does not cover the cost of service receive care from NUNM. Discounted care is determined by income, number of dependents within a household, and federal poverty level guidelines. While this model has made care more accessible for some socioeconomic populations, it has also made care more costly for those with higher socioeconomic status. Finally, as a further commitment to patient centered care, NUNM is working towards developing a patient stakeholder group that would meet monthly to garner additional information from patients to help ensure NUNM is delivery culturally competent care.

Conclusion

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 NUNM's vital contributions to this report since health care providers are looking to the leaders of integrative medicine to provide information on how to successfully create integrative PCMHs. By exploring the early adopters, we can identify the best practices, strengths and weaknesses of these models, and share this knowledge with others to advance the integrative professions.

The induction of naturopathic doctors as leaders of PCPCHs is an immense achievement for the profession of naturopathic medicine. Historically, the state of Oregon has embraced naturopathic medicine, and as a result of this openness, acceptance and inclusion, naturopathic doctors not only have the capacity to serve as primary care providers, but they are granted the ability to function as leaders of medical homes as well. The PCPCH model has also created more opportunities for other integrative providers, such as chiropractors and acupuncturists; and some of these disciplines have been incorporated into Medicaid services. The fact that naturopathic medicine is delivering quality care using a new model of medicine, demonstrates the profession's innate capacity for further inclusion at a much broader level. With the current policies in place that support integrative health care through the Affordable Care Act, it is indeed an auspicious time for the field of naturopathic medicine to further advance the profession by assuming more roles in primary care.

Appendix A

List of Integrative PCMHs compiled by ACIH

CAPHS: Assessing Health Care Quality from the Patient's Perspective

Compassionate Care Program

Defining the Medical Home: The Oregon Experience

Appendix B

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 not ask?