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Online Supplementary Material

McMullen CK, Schneider J, Firemark A, Davis J, Spofford M. Cultivating engaged leadership through a learning collaborative: lessons from primary care renewal in Oregon safety net clinics. *Ann Fam Med*. 2013;11(Suppl 1):S34-S40.

http://www.annfammed.org/content/11/Suppl_1/S34

Supplemental Appendix 2. Contextual Factors Relevant for Understanding and Transporting Findings From the Transformation to Patient-Centered Medical Home in CareOregon Clinics

- Public policy: CareOregon and Primary Care Renewal (PCR) participants are actively engaged in promoting state-level payment reform. At the end of our study, the state-announced payment reform to provide per-member or per-month payments for chronic disease management, and the Affordable Care Act is on the horizon. Specific health policy factors that affected our study included the following:
    - Oregon passed HB 2009 promoting development of the Patient-Centered Primary Care Home (PCPCH) and alternative payment approaches to encourage a focus on quality rather than services. Over the next 3 years, this initiative evolved into a certification process that would provide additional Medicaid reimbursement for implementing patient-centered medical home (PCMH) foundational elements (eg, enhanced access, clinician continuity, care coordination) and meeting and improving patient population metrics.
    - Passage of the American Recovery and Reinvestment Act in February 2009 provided considerable financial incentives for investing in electronic health records, allowing clinics to expand this valuable tool supporting PCMH care delivery but also dividing attention between electronic health record implementation and PCMH restructure for the following 2 years.
    - A site visit by Health Resources and Services Administration (HRSA) led to a requirement to dramatically increase clinician productivity, resulting in decreased organizational flexibility to implement key components of PCMH, a sharp fall in staff morale, and increased clinician turnover.
    - Marked expansion grants under the HRSA 330 grant programs during PCR implementation allowed some PCR organizations to plan for and begin redesigning clinical space to facilitate team-based care.
- Community: An epidemic of opioid use was overwhelming the clinics at the time of our study.
- Health care system:
    - The group of clinics studied were represented by their leaders in the Primary Care Renewal Steering Committee, which reflected remarkable collaboration and open sharing of performance data, challenges, and solutions in PCMH implementation. The committee started addressing issues other than PCMH implementation during the time that we observed their activities. These issues included a variety of topics: coordinating a community-wide response to the opioid abuse epidemic among the Portland metropolitan

area's safety net clinics and discussion of psychosocial "vital signs" that represent important data for clinics to assess about their patients.
    - In April 2008, CareOregon and PCR agreed to participate in the Commonwealth-funded Safety Net Medical Home Initiative in collaboration with the Oregon Primary Care Association (OPCA), which brought 8 additional clinics into the collaborative and divided leadership and technical assistance between CareOregon and OPCA.
- Practice: The study was conducted in primary care safety net clinics. PCMH implementation was not well funded, but it was accomplished, nonetheless, through modest incentive payments from a Medicaid payer and intensive coaching and collaborative learning facilitated by the Medicaid payer and grants (including a grant from the Commonwealth Fund).
- Other key stakeholders: OPCA was an additional key stakeholder in the PCR initiative.

The following factors changed in important ways over the course of the study: Opioid prescribing guidelines were enforced throughout PCR clinics—our clinic site visits included observations of care and communication around these new prescription guidelines. Steering committee meetings also included many discussions of this issue.

The following people worked together to identify the relevant contextual factors and to consider how they might have affected the internal and external validity of the study: Richard Meenan (principal investigator), Carmit McMullen (coinvestigator), and Mark Spofford (coinvestigator).

Interpretation of how these contextual factors affected what happened during the study and what others should know to transport/reinvent the findings in their contexts

Our qualitative data about initial efforts at PCMH implementation came from interviews with organizational leaders. Our observations of learning collaborative activities and care at clinic sites occurred years after the initial implementation. Originally, we hoped to link information from observations to quantitative claims data, but it became clear very quickly that the qualitative and quantitative efforts wouldn't inform each other much. The CareOregon claims data limited to great extent the issues we could examine quantitatively, and the ones we did examine had little to do with the ongoing learning collaborative and clinical care work. This situation was compounded by the fact that the site visits and interviews targeted individual clinics (and people), while the claims data were at the CareOregon level and combined data were from all clinics together. Any ideas we might have had at the beginning of a true mixed methods study ended early on.

Reflection on what was learned from the process of identifying and interpreting the important contextual factors for this study

We find it difficult to write at length about this process. The contextual factors table did not prove to be a discovery process for us because we have held regular team meetings where we have discussed these issues at length. We have also been thinking of these issues a lot in writing a series of internal reports representing the story of PCMH implementation for each organization we studied and in building a Web site to tell those stories.