guidelines including automated order sets, recommended screening labs, and referral information to weight management programs. For the 2012 initiative, CDIS will identify and monitor infants ages 0-2 with WHO weight/length ratio >95th% . Parents will be surveyed about their child's diet and physical activity. They will also receive age appropriate, simple written and verbal education materials based on the American Academy of Pediatrics Bright Futures 5-2-1-0 daily goals: 5-13 servings vegetables/fruits,

Keywords: Obesity; Intervention; Learning Health Care Systems

doi:10.3121/cmr.2012.1100.ps2-12

CA8-01:

Can the HMORN Transform Itself into a Learning Health Care Network?

Leif Solberg[1]; Greg Simon[2]; David Price[3]; Arne Beck[3]; Ameena Ahmed[4]; Enid Hunkeler[4]; Brian Ahmedani[5]; Karen Coleman[6]

[1]HealthPartners; [2]Group Health Cooperative; [3]Kaiser Permanente Colorado; [4]Kaiser Permanente Northern California; [5]Henry Ford Health System; [6]Kaiser Permanente Southern California

Background/Aims: The national case for learning healthcare systems was made in a 2006 Institute of Medicine (IOM) workshop. The IOM's vision was healthcare systems where "the process of generating and applying the best evidence will be natural and seamless components of the process of care itself." HMORN members have the potential to model this future, but few of them have yet achieved the necessary levels of integration with their affiliated care and insurance organizations and none fulfill the IOM vision. The Mental Health Research Network (MHRN) proposes to build such integrated relationships with each of its partner organizations and knit them together into a learning healthcare network for mental health in hopes of becoming a model for a future HMORN learning network. **Methods:** Phase I: a lead at each MHRN research group identifies appropriate leaders among their organizational partners and builds bidirectional relationships while identifying their mental health improvement priorities, researchable problems, and questions. Phase II: these new partnerships are formalized through periodic meetings and small projects while developing partnership grant proposals that address operational leaders' priorities . Phase III: we demonstrate the seamless generation and application of evidence within each organization desired by the IOM. Phase IV: we collaborate across MHRN members as a learning network and a template for the HMORN to become a learning healthcare network. **Results:** We are just beginning, building the relationships and trust that will turn into more formal structures in Phase II and shared projects and studies. Each site has a person to coordinate this effort and a list of important mental health affiliated leadership positions. The level of partnership varies from regular meetings at some sites to just beginning conversations at others. This presentation will quantify our progress, describe barriers encountered, and provide concrete examples. **Discussion:** MHRN and HMORN have an opportunity to be leaders in transforming health care by organizing and modeling learning through strategic bidirectional partnerships. If anyone can achieve the IOM vision, it should be us, but the path is unclear and the cultural and historical barriers are many.

Keywords: Learning Organizations; Partnership Research; Learning Health Care Systems

doi:10.3121/cmr.2012.1100.ca8-01

CA8-02:

Implementing a Community Health Initiative Using the Chronic Care Model

Carol Cahill[1]; William Beery[2]; Karen Lewis-Smith[2]

Group Health Cooperative[1]

Background/Aims: Group Health, an integrated care system serving 600,000 members in Washington state, has developed a community health initiative (CHI) based on the medical home and the Chronic Care Model (expanded to emphasize community health promotion). Primary care providers want to maximize their limited time and resources for encouraging healthy behaviors but often are unaware of the full range of community services that can augment and support clinic-based care. The overall goal of the CHI is to improve health outcomes by integrating patient-centered approaches with community- based programs and services that promote better health. **Methods:** A CHI logic model was developed that defines expected short term (phase 1), intermediate and long term outcomes for its primary audience (patients and providers), for Group Health as an organization, and for health-promoting community resources and environments. The CHI strategy involves development of a searchable, web-based database that allows providers to easily refer patients to community-based programs that promote active living, healthful eating, and effective chronic disease management. Focus groups were held with providers to determine database scope and content and secondary data were analyzed and mapped to identify where the most vulnerable populations in Group Health's service live. **Results:** During phase 1 the database is being piloted at a Group Health clinic in a high needs area in King County, to test clinical-community linkage strategies and to set the stage for replication throughout Group Health, among safety net providers, and in the community at large. The pilot phase evaluation is primarily a process evaluation, assessing characteristics of the program that contribute to its success, the creation of linkages to community resources, participant satisfaction, recommendations for improvement, and fidelity of implementation. **Discussion:** The interactive database shows promise as a tool for providers to engage patients in making healthy lifestyle choices and strengthening linkages between clinical practice and community resources. Piloting and evaluating the CHI will ensure the successful replication throughout Group Health, the safety net, and the broader community, and will contribute to the field by demonstrating successful linkages between primary care and community resources.

Keywords: Community Linkages; Chronic Care Model; Learning Health Care Systems

doi:10.3121/cmr.2012.1100.ca8-02

CA8-03:

Evaluating Primary Care Renewal in Oregon's Safety Net Clinics: Preliminary Quantitative Findings from CareOregon's Adult Medicaid Population

Richard Meenan[1]; David Mosen[1]; Sabrina Luke[1]; Nancy Perrin[1]

[1]Kaiser Permanente Northwest

Background/Aims: The patient-centered medical home (PCMH) holds great promise for improving care delivery. Primary Care Renewal (PCR) is an initiative, launched in early 2007, to transform Oregon safety-net clinics to the PCMH model of care. It is sponsored by CareOregon (CO), a Medicaid/Medicare managed care organization. The primary objective of this study was to conduct a quantitative assessment to identify utilization and cost metrics relevant to PCR practices and to evaluate PCR's degree of success in improving these metrics. **Methods:** The study population includes CO adult Medicaid enrollees assigned to 17 PCMH clinics (n=11,639) and 280 usual care clinics (n=64,686) over two time periods: 1) 18-month pre-implementation period (1/1/2006-6/30/2007) and 2) 33-month post-implementation period (1/1/2008-9/30/2010). A six-month break (7/1/2007-12/31/2007) was included as the PCR rollout period. Outcome measures include: 1) hospital days, ED visits, and primary care visits per 1,000 members per year and 2) per member per month (PMPM) medical costs (paid by CO). Utilization and cost information were obtained via claims data. Segmented regression models were used to compare post and pre-implementation periods for each outcome measure. Models were stratified by: 1) adult population (entire population) and 2) Expanded Diagnosis Clusters (EDCs, proxy measure for disease burden). Interactions of level change (post vs. pre-implementation) and clinic type (PCMH vs. non-PCMH) were assessed using segmented regression analysis. **Results:** We found a significant interaction of level change (post vs. pre-implementation) by clinic type for inpatient utilization (beta coefficient = -2.09, p-value = $p < .001$). Inpatient utilization was significantly lower immediately following implementation than just prior to the implementation. The level change by clinic type interactions were not significant for primary care visits, ED visits and PMPM medical costs. Stratification by EDC for each outcome measure will be completed by the start of the HMORN conference. **Discussion:** Preliminary results suggest PCMH was successful in reducing inpatient utilization after implementation, but no differences were found in other utilization metrics or medical costs. Study results were limited because no clinical quality information was available for analysis. Future research