Plan for Today:

• Introduce Richmond Clinic & Care Model
• Complex Care Management: Diabetes
• Describe Population Health & Transformation Efforts
• Approach to Building Capacity for Impacting Populations
• Addressing Key Challenges & Action Planning
• Think and Share!
This is Us!
Richmond Clinic’s Medical Home Journey

• SE Portland since August 1995; FQHC as of June 2012
• Annual visits ~ 57,000; 15,000+ patients
• Primary Care Redesign in 2006 implemented co-located Care Teams
• Recognized Oregon Patient Centered Primary Care Home (2011)
• 50% Medicaid, 20% Medicare, 5% Uninsured, 25% Commercial
• Oregon’s Medicaid Alternative Payment Methodology (2013)
Oregon Patient Centered Primary Care Homes

Accessible: Available when and where patients need
Accountable: Responsible for community served to provide quality, evidence-based care
Comprehensive: Patients get the care, information and services to get and stay healthy
Continuous: Providers know their patients and patients know their care team, develop relationships over time
Coordinated: Integrated care and coordination to navigate the system of care
Patient/Family Centered: Culturally responsive and patient-driven
Our Paradigm Shift:

What we had...

- A visit treadmill
- Care model built around needs of clinic and providers
- Usual clinic hours
- Minimal RN FTE on phones!
- Rigid provider compensation plan and shaky finances

What we needed:

- Trauma-informed community responsive care
- Enhanced Team Roles and “Share the Care”
- Expanded hours & visit alternatives
- Value-based payment
Why Complex Multi-Disciplinary Care Management?

- **Improved Primary Care Infrastructure:**
  - Preventive Services
  - Management of Chronic Conditions
  - Staff Wellness and Sustainability

- **Demand for Care Coordination by Primary Care Homes**

- **Increased Accountability**

- **Disparate Communities**
Care Model & Teams

Care Teams:
- PCP (4 FTE) and Medical Assistants (4 FTE)
- RN Care Manager (1.7 FTE)
- Team Coordinator
- Behavioral Health (1.0 FTE Social Worker)
- Clinical Pharmacist (.3 FTE)

All Clinic: PMHNP, MAT, BH Groups, Acupuncture, Yoga, Pharmacy, X-ray

Specialty: Sports Medicine, Pain, Integrated Medicine, ENT, Podiatry, High Risk Population Team
Innovative Team Member Roles

- REaCH Team & Palliative Care
- Social Determinants of Health Coordinator
- Complex Maternity Care Management
- Community Health Worker(s)
- Medical Legal Team
- Population Health Data Data Analyst
Where did we start? Care Management
Diabetes, of course!

- 1,100 active diabetic patients; 196 A1c > 9
- Stratification of patients
- Representative of complexity of our population

But why….really?
72 year old with >10 years of uncontrolled Type 2 diabetes severe peripheral neuropathy:

- A1c 12.4% and >20 medications
- 3 hospitalizations in the last year
- Many comorbidities…
Home visit revealed:

- Small, tidy apartment, food available
- Daily routine, supportive community
- Over 100 pill bottles and many expired items
- Goals to stay at home with his dog and improve quality of life
Sal on Care Management!

- Weekly RN visits, consistent schedule
- RN partnered with PCP and Clinical Pharmacist to reduce polypharmacy
- Regular goal checking
- Current A1c 7.1
- No hospitalizations!
- Independent at home
- No missed appointments
Care Management: The System of Care

- Panel management and routine outreach with segmentation approach based on A1c
- Medication Adherence & Administration
- Nutrition Coaching
- Motivational Interviewing
- Care Coordination
- PCP & Specialty F/U
## Comprehensive Coordinated Care

<table>
<thead>
<tr>
<th>Pre-Visit</th>
<th>During Visit</th>
<th>Between Visits</th>
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<tbody>
<tr>
<td>• TC’s scrub charts for updated DM labs and exams</td>
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<tr>
<td>• Provider/MA huddle to review and plan HM needs</td>
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<tr>
<td>• Order/perform labs</td>
<td>• Order and perform foot exam</td>
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<tr>
<td>• Order referral for DM eye exam</td>
<td>• Order other indicated HM needs for preventive care</td>
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<tr>
<td>• Warm hand-off: BHC for lifestyle changes, RN, Clinical Pharmacy, etc.</td>
<td>• TC’s perform outreach to schedule DM recheck</td>
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<tr>
<td></td>
<td>• TC’s enter outside results (eye exam, outside labs)</td>
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<tr>
<td></td>
<td>• F/u referrals</td>
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<tr>
<td></td>
<td>• RN visits</td>
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<td></td>
<td>• Clinical Pharmacy med rec and recommendations</td>
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<td></td>
<td>• BHC f/u visits</td>
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Clinical Pharmacy

- Medication Management
  - Appointment-Based Refills & Bubble-packing
  - Reconciliation
  - Optimization
  - Formulary Management
  - Diabetes: Collaborative Drug Therapy Management
Population Segmentation

• Evolving Methods and Systems...
  – Currently condition-based and care transitions
  – Explored risk scores; i.e. Charlson Index
  – Experience with payor based models
  – Integration of Social Determinants
Next up...

- Break – 10 minutes
- Addressing Barriers
  - Social Determinants of Health
  - Organizational and Systems
- Table Work: Opportunities and Action
Social Determinants of Health

• Social Determinants Screening Pilot
• Cooking Matters
• CSA & Community Garden
• Social Determinants of Health Coordinator
• Community Health Navigator
• On-site Medical Legal Partnership
Cooking Matters

- Partnership with Oregon Food Bank
- 6 Week Series
- Small interactive classes
- Nationally-supported curriculum
Richmond Garden
Community Supported Agriculture (CSA)

- Weekly Box of Fresh, Local Vegetables
- Affordable fresh produce
- Recipes and cooking classes
- Partnership with local farm
- **Cost:** $5 sign-up, $20/month feeds 2-4
Medical Legal Partnership

• On-site Legal Clinic x2 week:
  – Integrated approach to improving health status
  – Common referrals include housing, expungements, family and domestic issues, employment, DISABILITY
  – Doubled expected number of intakes in first year

• Clinic contracts for annual service
• Exceptional attorney and legal advocate
Our Ultimate Goal…

Oregon includes a 4th Aim for Health Equity for All
Building Capacity & Capability for Impact

- **Staff Engagement**
- **Alternative Payment Methods:**
  - Medicaid pm,pm
  - P4P for impacting shared measures (Medicare Stars, Medicaid Incentive)
  - Collaboration with Payers
- **Building the QI Team and Data Capacity**
Key to Our Transformation Experience

- Don’t take relationships for granted
- Networking up, down, all around!
- Continuous QI is ongoing evolution
- Responsive to community needs
- Staff and Patient Engagement
- Data is $
What is your clinic currently doing to address complex care needs?

- List assets that support your goals for complex care management
- Share out
What is getting in your way?
- List challenges & share

Recommendations for solving a common challenge?
Contact Us for More Info & Sharing!

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