



Complex Care Management: A Diabetes Case Study

Family Medicine at Richmond

Erin Kirk, MS, Quality Manager

Holly Herrera, BSN, Lead RN Care Manager

May 24, 2018

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!



COFFEE
EST. 1999
STUMPTOWN
ROASTED DAILY
ROASTERS



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 Analyst

Where did we start? Care Management



Into Action: Diabetes 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?

“Sal”

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...

Care Management Approach: Learning Sal's Story

- **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

Pre-Visit	During Visit	Between Visits
<ul style="list-style-type: none">• TC's scrub charts for updated DM labs and exams• Provider/MA huddle to review and plan HM needs	<ul style="list-style-type: none">• Order/perform labs• Order and perform foot exam• Order referral for DM eye exam• Order other indicated HM needs for preventive care• Warm hand-off: BHC for lifestyle changes, RN, Clinical Pharmacy, etc.	<ul style="list-style-type: none">• TC's perform outreach to schedule DM recheck• TC's enter outside results (eye exam, outside labs)• F/u referrals• RN visits• Clinical Pharmacy med rec and recommendations• BHC f/u visits

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



SHARE OUR STRENGTH'S
COOKING
MATTERS®
NO KID HUNGRY

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...

Triple Aim



Source: Institute for Healthcare Improvement

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 \$

Action Planning: Approach to Complex Care & Population Health

What is your clinic currently doing to address complex care needs?

- List assets that support your goals for complex care management
- Share out

Action Planning: Approach to Complex Care & Population Health

What is getting in your way?

- List challenges & share

Recommendations for solving a common challenge?

Contact Us for More Info & Sharing!

- Erin Kirk, Quality Manager kirker@ohsu.edu
- Holly Herrera, Lead RN Care Manager
herrerho@ohsu.edu