

Richmond Engagement and Community Health (REaCH) Team
A Community Based Collaborative
OHSU Family Medicine at Richmond (FMR) in partnership with CareOregon (CO)

The Issue: Total costs of providing care to Medicaid and other patients must be lowered, for the sake of national, state, and local economies and in the interest of promoting the health of the population. As a provider of primary care services, including behavioral health, to CO patients, FMR and CO have identified a subset of CO patients who have multiple risk factors associated with high risk of repeat hospitalization and/or Emergency Room (ER) visits. We believe that through special initiatives a significant amount of inappropriate hospital and ED utilization can be reduced without adversely affecting the health of the patients, hence lowering the total cost of health care for these patients.

The Goal: Through uniquely tailored interventions/investments in care improvement we will reduce rates of hospital utilization for a mutually agreed upon subset of patients most at-risk, and the total health care cost savings resulting from such reduced rates will be greater than the budgeted costs of producing this outcome.

The Approach: There will be a combination of community/home-based interventions and clinic-based interventions focused on the mutually agreed upon subset of patients (some will be identified as not amenable to change or to ambulatory care interventions and, therefore, excluded). A theme with this population is that doing the right thing needs to be made easier for them. This often involves stipulation of clearly structured steps to promote their health, and removal of basic barriers like transportation, for example. It also involves improving primary care team relationships with the patients, primarily through having more frequent or productive “touches”.

The REaCH team is well equipped to provide patients with the following services or outcomes:

- increased engagement with clinic
- support and advocacy for patients during medical visits (PCP/Specialty)
- facilitated goals-of-care and palliative conversations
- support with medication regimens
- training in harm reduction approaches to high risk behaviors
- decreased social isolation via social contact in community
- opportunities to meet in the community, outside of clinic or hospital settings
- option to communicate via text message
- community and/or home visits with RN or PharmD
- assistance w purchasing health-related goods not covered by insurance
- fast-track requests relating to benefits via CareOregon
- facilitated ADS evaluations, accelerated foster home placements
- initiate or improved connections with community resources including housing and MH services
- facilitated engagement with Richmond behavioral services (DBT, etc)
- connect patients with peer wellness

In addition, the Palliative/Advanced Illness arm of the REaCH team can:

- support simplification and consolidation of care via reduced polypharmacy, home surveillance, specialty communication and alignment, advanced care planning.

The Team Members:

Health Resilience Specialists (HRS) x3, non-medical, optimal panels 75 engaged pts/year – an essential part of the model, engaging with patients over several months to provide continuous, trusting relationships via a range of interactions, including a myriad of different types of touches – ie text messaging , walks in the park, accompaniment to medical appts, etc.

Care Coordinator – the “glue” who holds the whole thing together in efficient and accountable fashion. Provides a direct communications link with the HRS, provides daily surveillance and PCP/RN communication re hospital admissions (all FMR patients admitted to OHSU, all Medicaid patients admitted in metro PDX), is the primary linkage point between OHSU discharge teams and FMR, coordinates hospital f/u visits and minimizes barriers for patients attending those visits, tracks upcoming specialty appointments for engaged patients. Daily work includes compiling admitted and recently discharged patient census in preparation for weekly team huddle.

RN Care Manager – Telephonic clinical surveillance post-hospitalizations, home visits with HRS as needed, clinical support for first 30-60days post discharge as determined on case-by-case basis.

Pharmacist – Assume responsibility for medication reconciliation with all engaged patients willing to transfer prescriptions to FMR pharmacy; medication reconciliation for recently discharged patients; synchronize refills to the greatest extent possible so that pick-ups occur all together and in conjunction with a visit for other purposes. Support with de-prescribing for palliative/advanced illness patients.

Palliative/Advanced Illness RN – Palliative-trained RN partner who can conduct intensive home surveillance and support PCP in care of patients meeting criteria for advanced illness care (but not yet at hospice stage).

Advanced Illness Resilience Specialist – Health Resilience Specialist with unique capacity for supporting patients in advanced stages of illness, particularly in domains of end of life planning in the context of advanced illness.

Project Lead (MD) – Provides project oversight, clinical guidance, infrastructure development/design and collaborates with CareOregon partners.

- I. **Core Huddle Activity:** Our team assembles WEEKLY, for one hour, to review the currently admitted and recently discharged CareOregon Richmond patients, using the Huddle Tool, a registry of these patients and salient details that inform our case conference. During this meeting we review each case, using a range of variables to determine the degree to which we perceive risk of readmission, and discuss next steps pertaining to who will follow up with patient and PCP.

Contact for questions:

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