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"She/Her/Hers"

Options for Southern Oregon

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DISCLOSURES

I have no conflicts of interest or other disclosures

Options for Southern Oregon

Options for Southern Oregon includes a
5 Star Patient Centered Primary Care Home
as well as being recognized as a
Certified Community Behavioral Health Clinic (CCBHC)

Mission:

"Options for Southern Oregon serves people of all ages in our community who have mental health and physical health needs. Our holistic approach addresses housing, advocacy, community integration, crisis intervention, therapy, co-occurring issues, education, work, and economic well-being. We foster the development of mental, physical, and emotional health in children, adults, and families, and support our clients' participation as respected members of the community."

How We Started

Initial conversations with staff:

- There were rising needs regarding physical health care issues with our patients.
- People with mental health diagnosis die on average 25 years earlier.
- Case managers had limited engagement on the primary care side when working with patients.
- Education process was initiated among staff.
- With the support of AllCare CCO and Primary Health CCO the decision was made to open a primary care clinic located in our adult services building.

Next Steps

- **Weekly staff meetings discussing the importance of physical health such as side effects of medication and comorbidities.**

- **We hired an office manager consultant- who set up our policies and procedures. This was the key - before we opened our doors.**
  The consultant assisted with the following:
  - **Creating policies and procedures.**
  - **Understanding scheduling for primary care.**
  - **General daily operations for primary care clinics.**

- **AllCare, one of our CCO's, agreed to help us with billing.**

- **Continued staff support around understanding primary care.**

- **The primary clinic opened in August 2013.**

PCPCH Journey

- Started in 2014
- Measures were reviewed and compared to current practice.
- Gaps in our current practice model were identified.
- Barriers to closing those gaps were identified.
- Goals were identified to bring practice inline with measures by:
  - Establishing teams responsible for each goal.
  - Working with our CCOs for ideas on implementation.
  - PDSA cycles for areas we need to change.
- Weekly meetings established for strategizing.
- We took the leap and submitted the application.

Patient Centered Primary Care Home

2015 Achievements

- **Options for Southern Oregon earned Tier 3 PCPCH status!**

- **We were also selected to be part of the Behavioral Health Home Learning Collaborative.**

5 Star Journey

- **Started in 2016.**
- **New binder created.**
- **New measures reviewed with staff.**
- **Barriers and gaps identified:**
  - **We needed to review polices.**
  - **We needed to increase open access appointments.**
  - **We needed to learn to capture more data and report out.**
- **Increased our meetings and work group sizes.**
- **We increased internal QI/QA involvement for date reporting, policy creation/revision.**
- **STAFF TRAINING!**
  - **Support staff had to become more fluent on pulling reports from EHR, using patient portal, and implementing same day scheduling.**
  - **Case Managers and skills trainers became more fluid between PCPCH and psychiatric knowledge.**
  - **Learning how to take care coordination to a new level internally and externally.**
  - **Everyone learned how to capture data! (we are *STILL* learning)**

Barriers and Solutions

- **TIME! Staff pushed back a lot due to not enough time to do the new demands.**
  - **We had to rethink HOW we did things**
  - **Workflows were changed to maximize productivity**
  - **Roles were redefined to distribute duties**
  - **New staff brought on for administration burdens**

- **No comparisons! No recipe for how to do this in our setting!**

- **Learning how to capture data. Our CCOs helped us create templates, reports and assisted with staff training.**

- **Staff burnout. Too many things to do, not enough people to do them. High acuity patients. Self Care and teamwork where key here!**

- **We worked through it and we submitted that application!**

Patient Centered Primary Care Home

2017 Achievements

- **Options for Southern Oregon earned 5 STAR PCPCH status!**
- **We were also selected to participate in Project ECHO.**

Site reviewers, AllCare staff, and PCPCH staff celebrating the 5 Star achievement!

Internal Care Coordination

- Assertive Community Treatment
- Case Management
- Crisis Resolution Center
- Peer Recovery Specialist
- Psychiatric Medical Unit
- Support Staff
- Therapist

Assertive Community Treatment

- **Assertive Community Treatment: service-delivery model that provides comprehensive, community based treatment to people with severe and persistent mental illnesses.**
- **Daily huddles with PCP in attendance at least once weekly**

Members of the ACT team include:

- **Psychiatric Provider**
- **Case Managers**
- **Skills Trainers**
- **Co-occurring Specialist (mental health and addictions)**
- **Nurse**
- **Mental Health Therapist**
- **Employment Coordinator**

Case Management & Skills Trainers

Case Management

Utilizes evidence-based Strengths treatment model to help each individual recognize and utilize his or her unique strengths, abilities and potential.

Skills Trainers

Mentor and teach patients the skills needed to successfully manage one's life at home, work, and other community situations.

Both teams huddle with PCPCH team weekly and come into clinic with patients for their appointments

Crisis Resolution Center

Our Crisis Resolution Center (CRC) is a co-occurring (mental health and addictions) treatment facility, specializing in providing secure psychiatric and addictions stabilization and respite services for our community. The first of its kind in Oregon, it continues to be one of the few programs with "Non-hospital Hold" and co-occurring treatment capability. The CRC and the CRC Campus house multiple mental health and co-occurring treatment programs and supportive activities such as co-occurring self-help groups and emotional skills groups.

Peer Recovery Specialist

Peer Recovery Specialist: use their personal experiences to model recovery, teach skills and offers support to help people be successful at work, school, home and the community.

Illness Management and Recovery group co-facilitated by peers and therapist

Peers often accompany patients on their medical appointments

Psychiatric Medical Unit

The medical unit is operated in the same building as our PCPCH. There are psychiatric nurse practitioners and physicians along with and injection clinic RN, MAs, and an in house medication delivery service with lab draw services. This unit is responsible for psychiatric evaluations and medication management.

Weekly med unit meetings include the PCPCH and Psychiatric teams.

Adult Resource Team

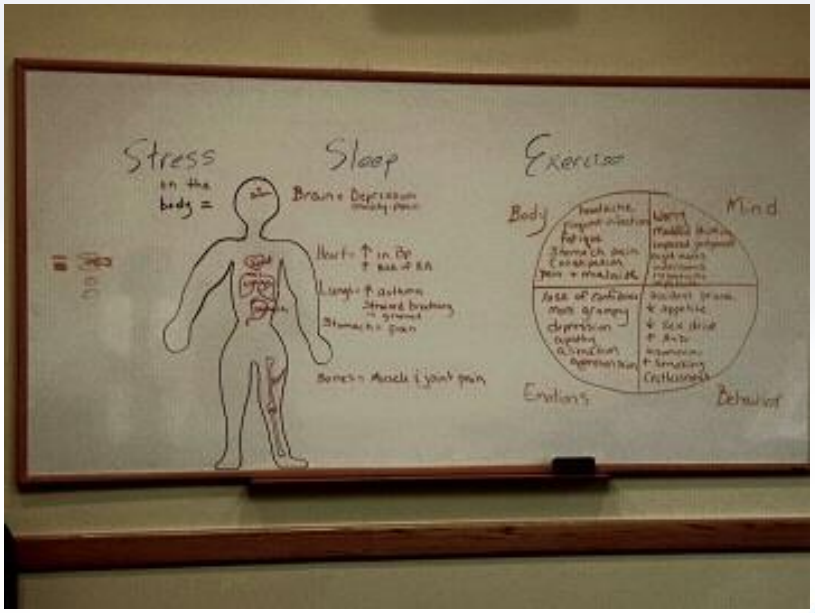
The ART department consists of our therapist who use a variety of treatment models including evidence-based practice models such as Cognitive Behavioral Therapy (CBT), Eye Movement Desensitization and Reprocessing (EMDR), and Dialectical behavior therapy (DBT). An individual assessment of each person's strengths and needs helps to guide the therapy approach.

Collaboration between the PCPCH and ART:

- **Multidisciplinary Physical / Behavioral Health and Wellness Group.**
- **Huddles and case by case interactions**
- **Therapist coming to clinic when safety screen is needed**
- **PCP having access to treatment plans and goals patient is working on to support patient.**

Wellness Group

- **Multidisciplinary Physical / Behavioral Health and Wellness Group co-facilitated by PCP and Therapist**
- **5-12 patients meet once a week for 12 sessions lasting 90 mins.**
- **Sessions are bifurcated into a didactic component and a skills training component.**
- **Healthy, AFFORABLE, nutrition snacks are part of the experience.**



External Care Coordination

Operational

- Assistance with policies, procedures, and work flows
- Provides support in attestation process for PCPCH status
- Alternative Payment Model (APM) support in efforts to improve the triple aim
- EHR implementation, training and ongoing support
- Provide gap lists of patients who need services

Direct Care

- Health and wellness education classes
- Transportation
- Community Care Workers
- Care coordination services from CCO
- Behavioral health integration assistance
- Social Determinants of Health Community engagement

Keys to our success

- **We changed the way we communicate.**
- **Changing the way we think – working from a prevention mindset.**
- **Huddles.**
- **Collaboration between PCP and Psychiatric providers.**
- **Increasing open access to care.**
- **Increasing education with staff.**
- **Increasing education with patients.**
- **Continued collaboration and nurturing relationships with community partners.**

Why is integration important?

70 white female. Past medical history includes:

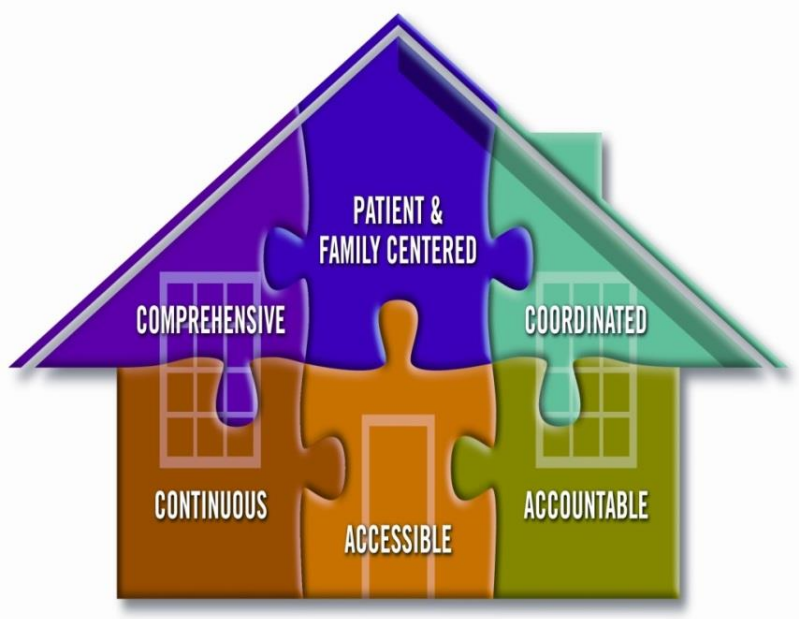
Anemia, atrial fibrillation, bilateral cataracts, bipolar disorder, cholelithiasis, coagulation defect, diabetes mellitus II, diverticulitis, dyslipidemia, nocturnal enuresis, hypertension, hyponatremia, hypothyroid, internal hemorrhoids, metabolic encephalopathy, migraine headache, Parkinsonism, peripheral neuropathy, recurrent UTI, schizophrenia, septic shock, stage 5 chronic kidney disease (GFR 10), thrombophlebitis, abnormal uterine bleeding.

- **Refuses dialysis**
- **Refuses anticoagulation**
- **Refuses home health care**
- **Refuses to engage in any recommendations for all most everything discussed**
- **Agrees to case management**
- **Agrees to taking her mental health medications**
- **Agrees to working on nutritional health**
- **Agrees to hugs ☺**

Core Attributes

- **Access to care:** Patients get the care they need, when they need it.
- **Accountability:** Recognized clinics are responsible for making sure patients receive the *best possible care*.
- **Comprehensive:** Clinics provide patients all the care, information and services they need.
- **Continuity:** Clinics work with patients and their community to improve patient and population health over time.
- **Coordination and integration:** Clinics help patients navigate the system to meet their needs in a safe and timely way.
- **Patient and family-centered:** Clinics recognize that patients are the ***most important*** members of the health care team and that they are ultimately responsible for their overall health and wellness.

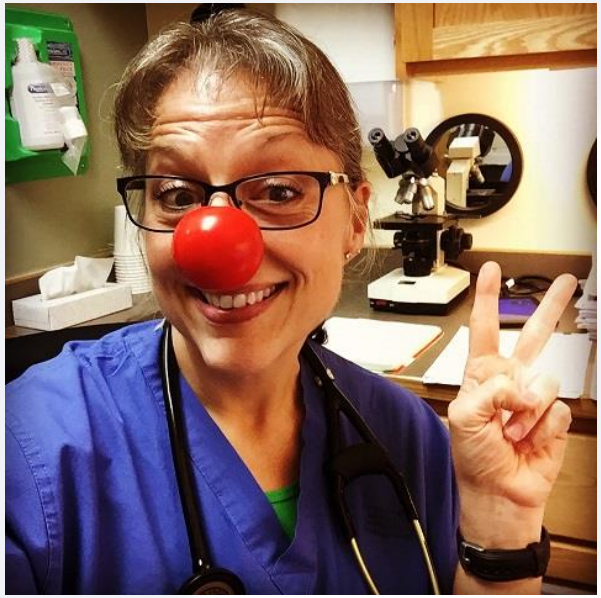
(oregon.gov)



THANK YOU!

It was an honor to speak with you all today! I look forward to being able to continue to do the work I do because of the work you all do!

Always remember, laughter IS a strong medicine!



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