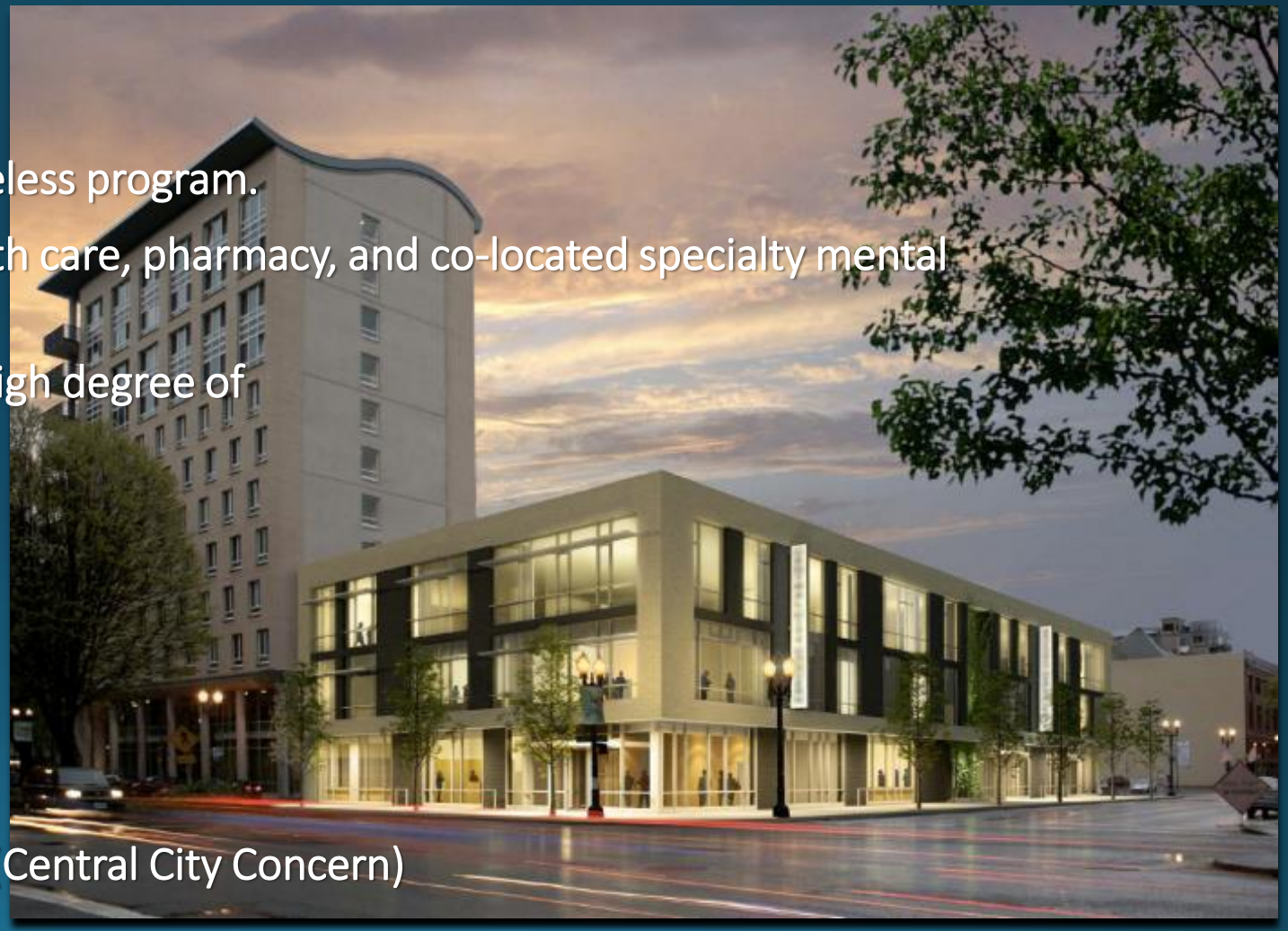

THE SUMMIT TEAM AT OLD TOWN CLINIC
PROVIDING CARE COORDINATION TO A UNIQUE POPULATION

Old Town Clinic

- Portland, OR (Medicaid Expansion State)
- FQHC and designated Health Care for the Homeless program.
- Provide integrated primary and behavioral health care, pharmacy, and co-located specialty mental health and substance use disorder services.
- We serve 5,000 patients per year, who have a high degree of

medical, behavioral and social needs:

  - 77% have a mental health disorder
  - 69% have a chronic medical condition
  - 60% have a substance use disorder
  - 60% are experiencing homelessness
- Robust team based care within PCMH model
- Embedded within larger social services agency (Central City Concern)



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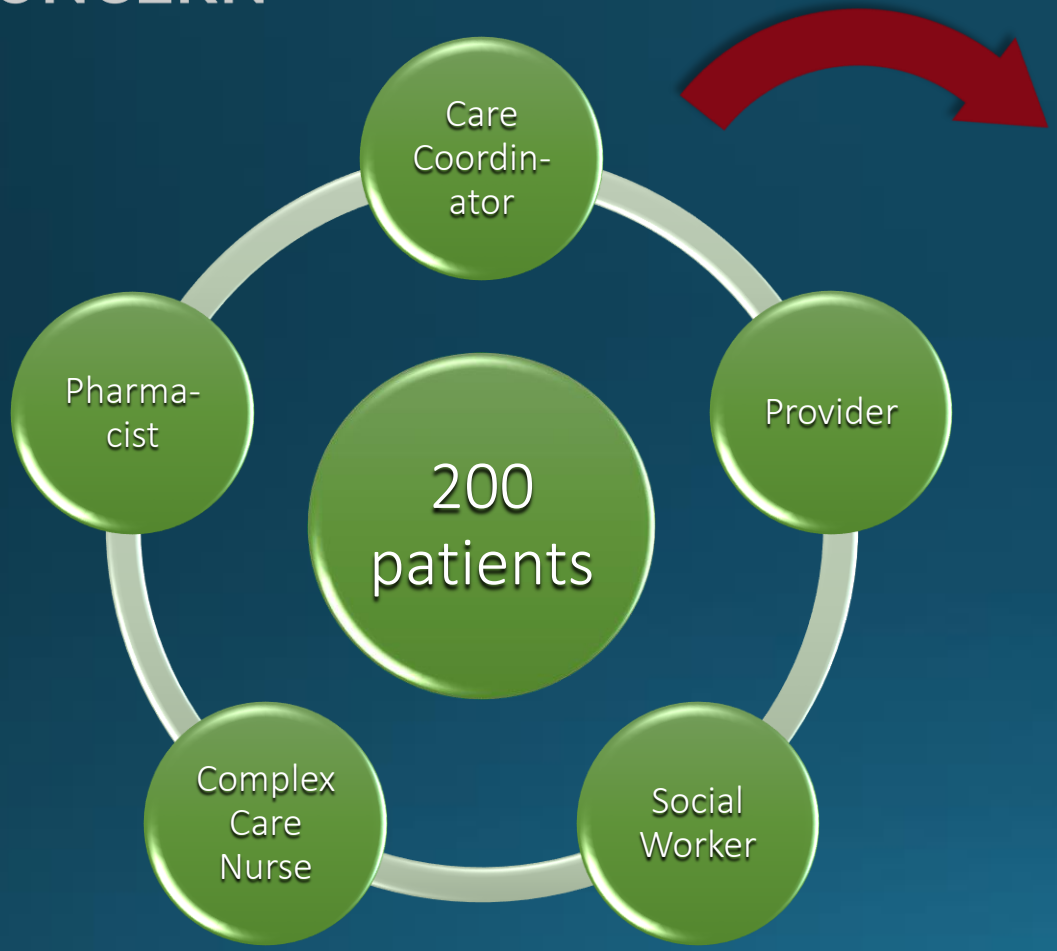
SUMMIT TEAM MODEL



Allows more time to:

- ***Build relationships***
- Outreach
- Provide timely support
- Increase access to team
- Smooth transitions of care

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Who We Are

Care Coordinators
- Jenn and Mike

Nurse
- Tonya

Pharmacists
- Jan & Theo

Social Worker/Addiction Counselors
- Heather & Scotti

Medical Providers
- Meg and Richard

Team Manager
- Jason

Health Coordinator
- Andrew

Data and Quality Specialist
- Matt

Research Assistant
- Anna

Principal Investigator
- Brian

Consultants (MD, PMHNP, & LCSW)
- Brianna, Susan, and Tressa

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What We Do

- Foster relationships
- Ensure access to primary, specialty, and behavioral health care
- Facilitate utilization of outpatient care
- Manage care transitions
- Provide psychosocial and material supports

Research: Why study Summit? Why study ourselves?

- Learning opportunity to study how we can improve care for this population
- Advance science of managing medically and socially complex patients holistically
- Funders and stakeholder accountability
- Learn about ourselves and what makes OTC a model for innovation
- Summit is our learning lab for how we care for complicated patients

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That Quadruple Aim

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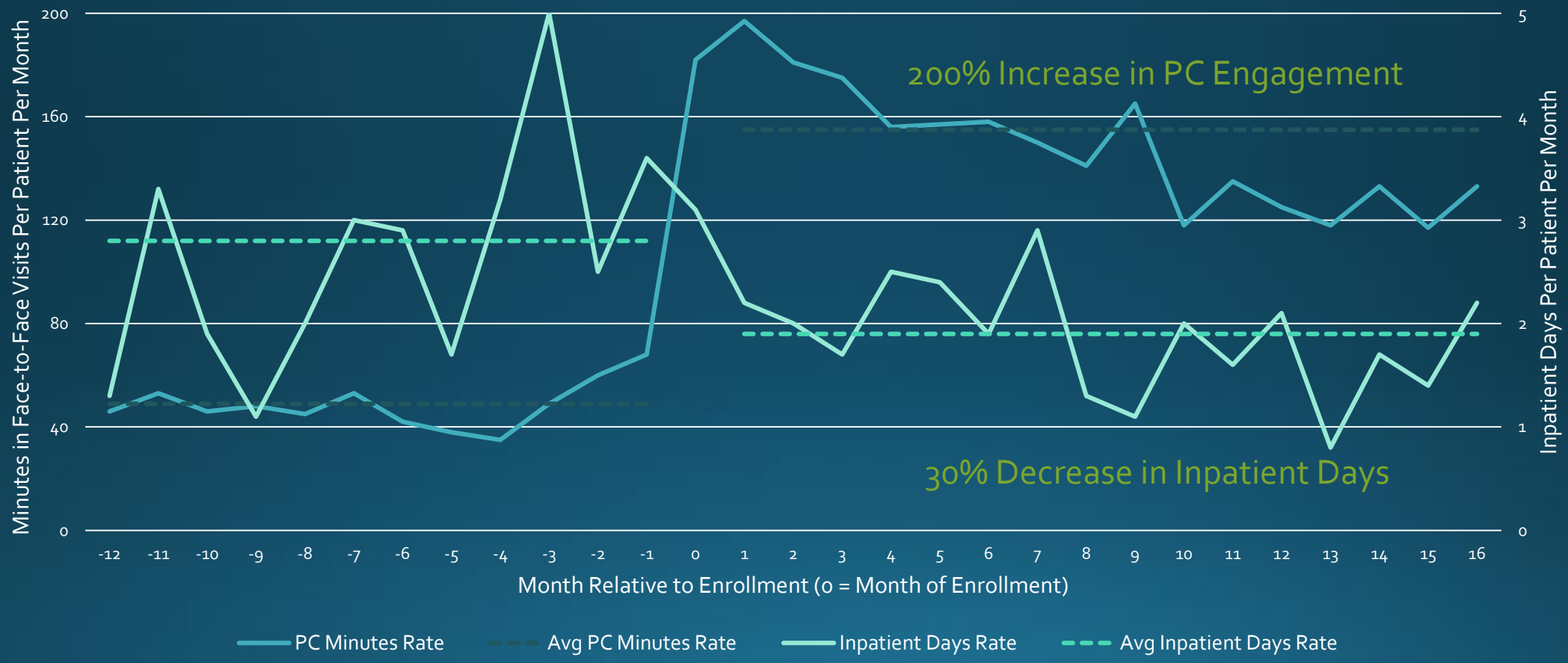
Primary Care Engagement vs. Hospital Utilization



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Who is a SUMMIT Patient?
Kim

Kim is a 65 y/o white woman with the most kind and thoughtful disposition, unmatchable wit and humor, and she's also super stylish

Goals: Move into a home with caregiver supports, stay out of the hospital, get a power chair, hang out with her friends, and engage in MH treatment

Diagnoses: COPD, CHF, Type 2 Diabetes, a rectal prolapse, PTSD, Anxiety & Panic Attacks

In and out of hospital over 10x the last 6 months

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Who is a SUMMIT Patient?
Kim

Kim is “residentially challenged,” in and out of various shelters for years

Financial and legal barriers have made housing extremely challenging

Approved for AFC/ALF; however, barriers have severely delayed placement

“I’m so tired, Heather, and I feel so weak. It’s scary out there. I need help. I can’t care for myself. What am I going to do?”

Who is a Summit patient?

Difficulty managing medical conditions when they do see the PCP due to behavioral/substance use issues

Lengthy problem/medication list

Lots of no shows/not engaged in primary care

Frequent hospital re-admissions

They can feel traumatized or alienated from the healthcare system

High degree of chaos

Systemic and historical barriers to accessing care

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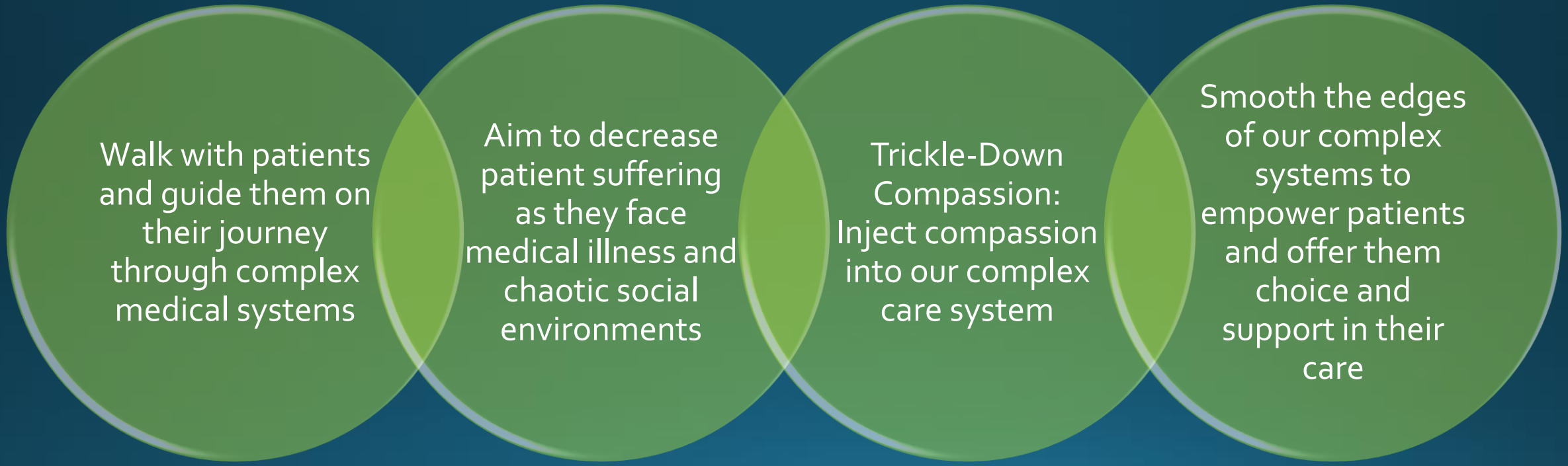
Care Coordinators



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Care Coordinator Roles

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Care Coordination
A New Diagnosis

Care Coordinators (CCs) can provide meaningful warmth and support

CCs provide crucial communication between patients, specialists, and PCPs to avoid gaps in care and ensure patients needs are being met

Navigating our systems can be complex and daunting - CCs can sometimes take responsibility for tasks that overwhelm patients

CCs can provide further support and advocacy by sometimes accompanying patients to appointments.

CCs are able to help improve outcomes for patients and providers by offering individualized support and follow-through

Who is a SUMMIT patient & how can SUMMIT help?

- Someone with advanced medical illness who has a hard time engaging in primary care
- Someone who may benefit from longer appointments and increased care coordination and navigation
- A patient who may not go to the ED often, but when they do they are often admitted for a medical issue

- Summit can do occasional home visits, hospital visits and accompany patients to specialists appointments
- Most Summit appointments are 60 minutes. Care Coordinators assist in navigating the healthcare system
- Summit can assist with care transitions and med management

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Common Co-Occurring Issues our Patients Experience

- Chronic Kidney Disease
- Congestive Heart Failure
- COPD
- Chronic/Severe Infections and Wounds
- Diabetes
- End Stage Liver Disease

- Trauma
- Anxiety
- Depression
- Substance Use
- Severe & Persistent Mental Illnesses

- Homelessness & Unstable Housing
- Food Scarcity
- Poverty
- Barriers to accessing a myriad of resources for care and basic needs

What does Summit do?

- Comprehensive patient intakes
- Care transitions
- Close follow-up, Outreach & home visits
- Offers longer appointments, after-hours line
- Healthcare navigation & support
- Behavioral health and addiction medicine specialists
- Accompany patients to specialist appointments

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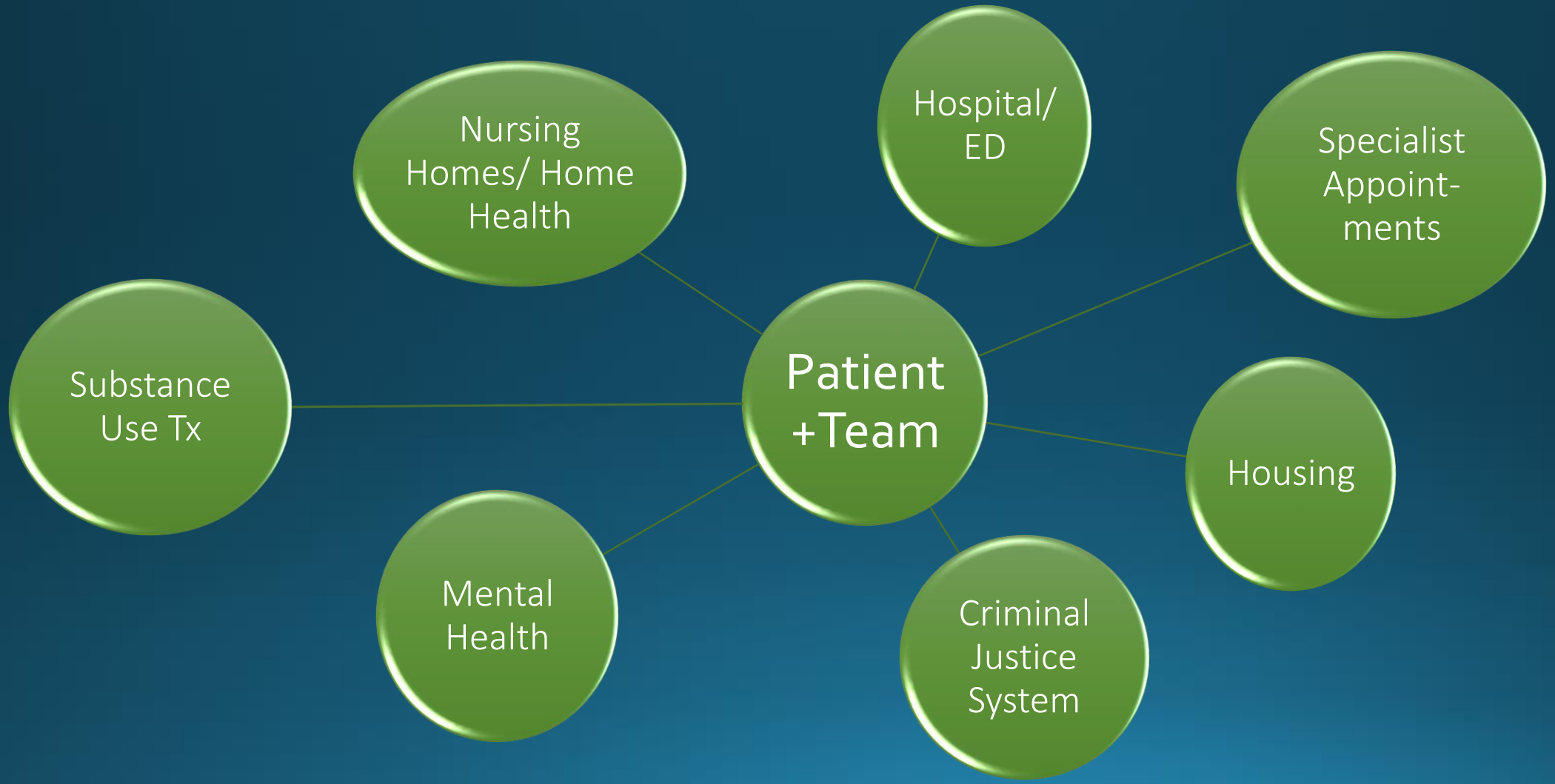
Core Activities: Transitions of Care




PalliativeCare
SunshineDivision
CareOregon
RCF
SubsidizedHousing
LionsClub
MealsOnWheels
ADVS
SOSshelter
PayeeServices
OTRC
SocialSecurity
RotaryClub
Hospice
HomeForward
Tricounty911
UnityDME
CoPaws
OHP
DMVsNF
AdultCareHomes
Blackburn
Hospitals
AlliedRCP
IHart
Coda
Trimet
LegalServices
CommunityWarehouse
RideToCare
AssistedLivingFacilities
Radiocab
HooperDetox
Snap
DentalServices
Join
Cascadia
Medicare
TPI
DDS

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Challenges We Face
A Patient Case Study

Background

- 27 y/o African American male, lived in an AFH and not happy with his care
- Used a power chair for mobility
- Required very specific ostomy supplies due to the nature of his abdominal surgeries
- Wanted fistula reversal surgery

Pertinent Medical History

- Short-gut Syndrome secondary to abdominal GSW
- Multiple abdominal surgeries and fistulas
- Bilateral AKAs
- Illeostomy
- History of SBOs

Prominent Issues When Arriving to SUMMIT

Frequent hospitalizations due to n/v, electrolyte imbalances, dehydration

Nutrition deficiencies due to short-gut syndrome

Flux within Housing – not happy with care at his AFH, push-back from the home about patient

Patient desire to Re-establish with gastroenterology and revisit surgical options

Difficulty obtaining needed ostomy supplies – insurance no longer covered the brand he was using

Pain

Management

Summit Team Interventions

Patient moved to a new AFH, good rapport with the caregiver

Appointments made with GI surgery team (team was familiar with patient), dietician

Plan for port placement with home health support for administering IVFs with vitamin supplementation

Pain management plan with primary care provider

Connected patient with wound/ostomy nurse to figure out a new plan for ostomy supplies

Assistance with scheduling required tests prior to any surgical intervention

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Successes and Sorrows

Patient developed a good relationship with the new AFH caregiver

Patient became very engaged with the Summit Team

Patient was glad to begin the necessary studies and procedures in order to have surgical intervention

Patient was not entirely adherent with home health schedule for IV fluids and nutrition

Patient continued to often use the ED when in distress

During one of the pre-surgical studies, Patient had an aspiration event and subsequently died.

All Those Systems Challenges

- Gaps in care
  - TBI resources
  - Trauma informed settings for respite/long term care
  - Hospice for socially vulnerable patients
  - Substance use disorder treatment services for medically complex individuals
- Maintaining patient trust across systems
- Retaining team flexibility to accommodate patient needs while growing
- How do you measure success?
- “Winning” the financial case

Challenges – Clinical

- Relationships are non-linear
- Relationships are intense and often we share risk in a different way
- Controlling what you can control
- What comes with holding a high level of respect for autonomy and self determination?
  - Getting comfortable with allowing people to make “bad” decisions
  - Experiencing the risks and consequences associated with those decisions alongside people

Fostering "Teamness" for Sustainability

Evidence & Practice based team trainings in Palliative Care, Motivational Interviewing, Trauma Informed Care, DBT

Team wellness and daily group meditation practice

Team discusses use of flexible funds to help with non-traditional care needs as they emerge

Team shares and celebrates successes

Interdisciplinary nature offers real time supports for challenging clinical scenarios (Warm Hand-Offs)

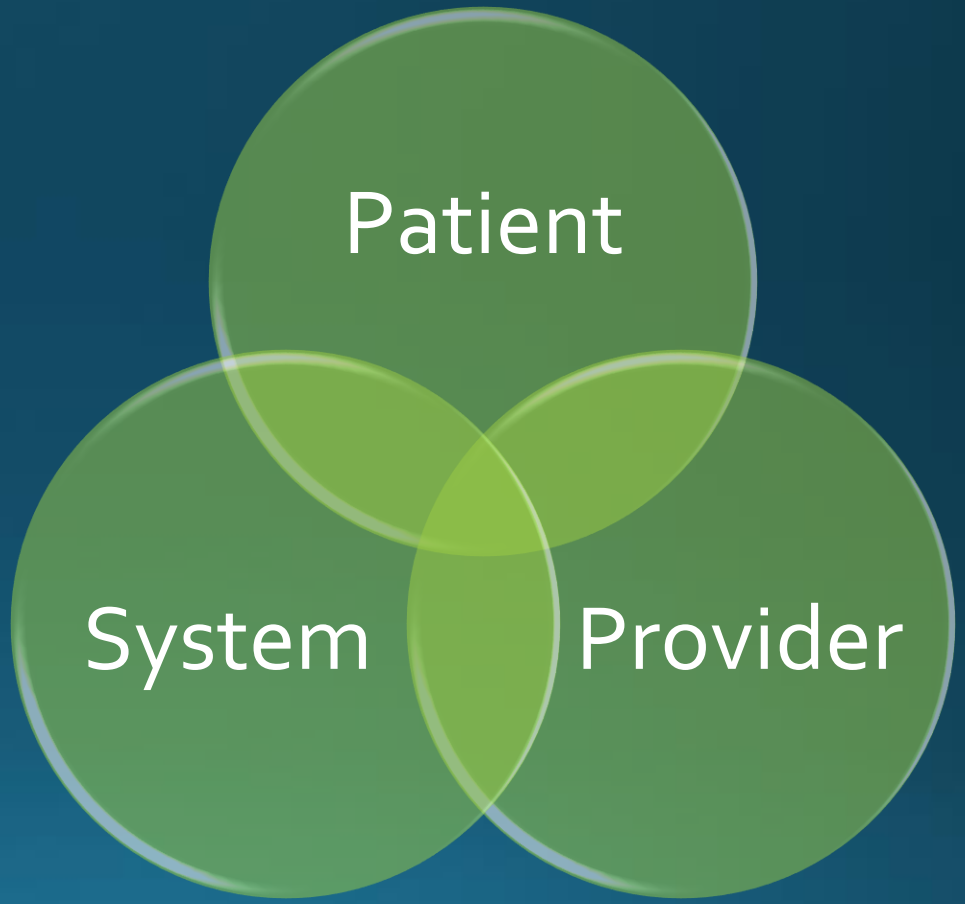
Team collaboration happens naturally as issues arise

Weekly team meetings to reflect on work, participate in quality improvement exercises and implementation

More Systems Work, Self-Care & Sustainability

- Our work as an Interdependent Experience
- Validate → Educate → Support
  - ***Leadership:***

Creating a culture that truly encourages, incentivizes, and makes space for wellness, sustainability, & self-care



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What Next?

- Better defining success through patient/provider experiences, outcomes, cost data
- Increased patient activation/self management
- Ongoing team role delineation
- Partnerships with hospitals/care homes
- Building expertise and sharing best practices
- Securing long term funding/payment reform?
- Qualitative and Quantitative research findings


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QUESTIONS?