PCHC
PROVIDENCE COMMUNITY HEALTH CENTERS

Population Health

More than Just Primary Care Delivery

Innovation, Best Practices, and Musings from a Multi-specialty Urban Community Health Center

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Chief Medical Officer

CTC – Clinical Strategy Committee Theme for 2021

Care Delivery Design to Maximize Success Under Comprehensive Primary Care Capitation and Total Cost of Care Risk

Comprehensive Primary Care

CARE DELIVERY DESIGN

- Adult and Pediatric
- Expanded Role of Care Team
- Workforce Wellness and Development
- Improve PCP--Specialist Collaboration
- Increase High-Value Care (Reduce Low Value Care)
- Pediatric Learning Community

COMMUNITY HEALTH

- Community Health Team Innovation
  - Serve patient and family
  - Engage with community and stakeholders broadly
  - Engage with hospitals and health plans
- Rhode to Equity
  - Building community clinical linkages
- Financing and Sustainability

MAXIMIZE TECHNOLOGY

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

CTC – Clinical Strategy Committee Theme for 2021

Graph courtesy of Freedman Healthcare

The Usual Caveats

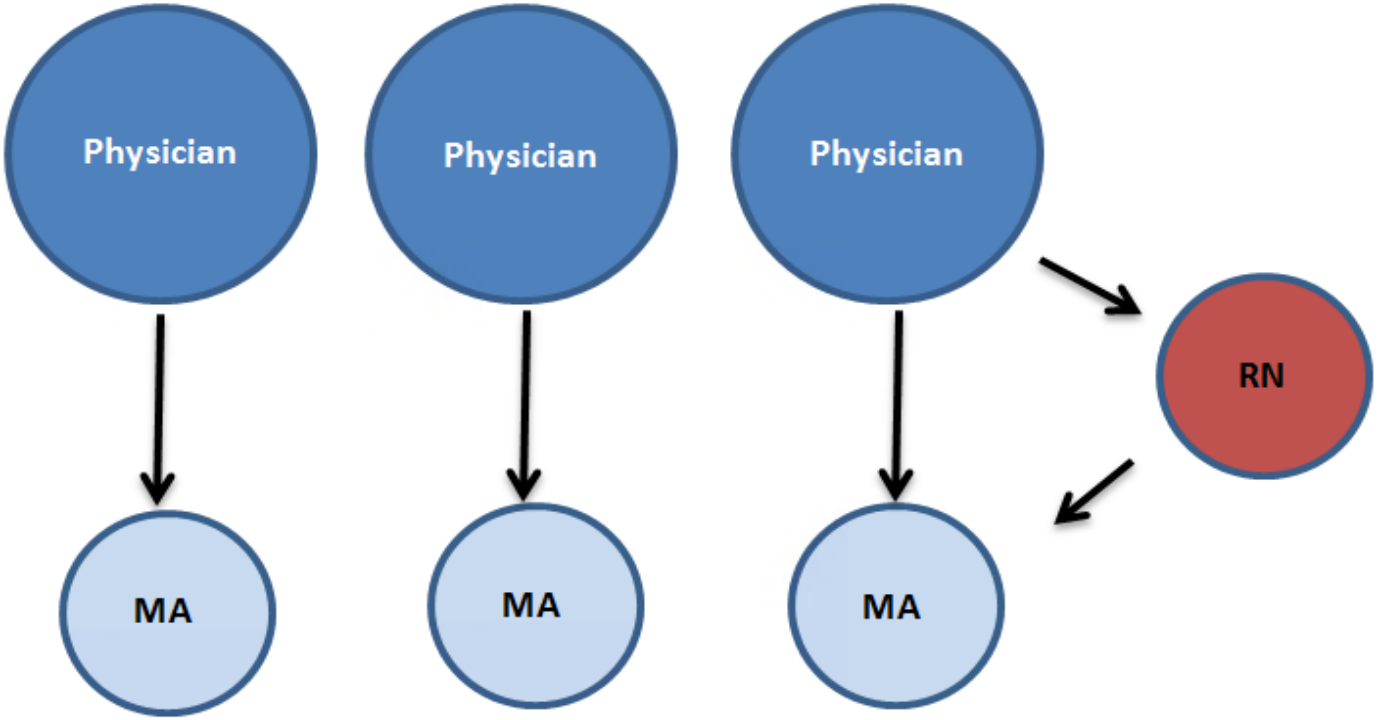
- FQHCs have had a different reimbursement mechanism.
- With the shift towards capitation, health centers now face the same pressures as private practices to reinvent primary care delivery.
- Many of our population health strategies are the same as those used by ACOs and private groups.
- Traditional practices need extensive infrastructure to broaden their scope for population health management.
- Sustainability is everything.
- One size doesn't fit all.

Providence Community Health Centers

- **60,000 patients**
  - 25,000 under the age of 18
  - 70% Medicaid, 10% Uninsured, 10% Medicare
- **8 clinics**
  - Multi-specialty (Peds, Fam, IM, Ob-Gyn)
  - Several specialties are on staff in-house
  - Large urgent care
- **Medicare ACO** since 2014
- **Medicaid AE** – PCHC is a single agency AE
- Some **commercial capitation** contracts

Primary Care Delivery

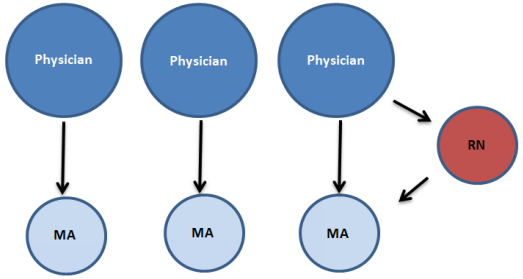
The Historical Primary Care Model



Primary Care Delivery

The Historical Primary Care Model

What Can Go Wrong?



Quality Outcomes Vary Because:

1) It's clinician-dependent (vertical)
2) No one has time for preventative services
3) Workforce is inadequate to scale up this model to serve 350 million Americans
4) Relies on face-to-face visits
5) Care delivered only to those who show up
6) Clinician burn-out

Sacred Cows and Paradigm Shifts

Who ever said…

- The physician had to do everything?
- Medical knowledge can only be dispensed by the physician?
- All care had to be delivered 1:1 in 15' units?
- All care had to be performed face-to-face?
- All care had to occur in a clinical setting?

Sacred Cows and Paradigm Shifts

Does your system require a face-to-face visit to obtain routine preventative services or close "gaps in care?"

Do your primary care teams to have time to track down everyone who needs a preventative service?

Uncouple Your Preventative Services from Direct Care!

RNs and MAs at the top of their license

Patient Engagement Coordinators behind the scenes

Sacred Cows and Paradigm Shifts

Open Access Scheduling - The Two-Edged Sword

Patients who can navigate it - *love it*

But it favors survival of the fittest

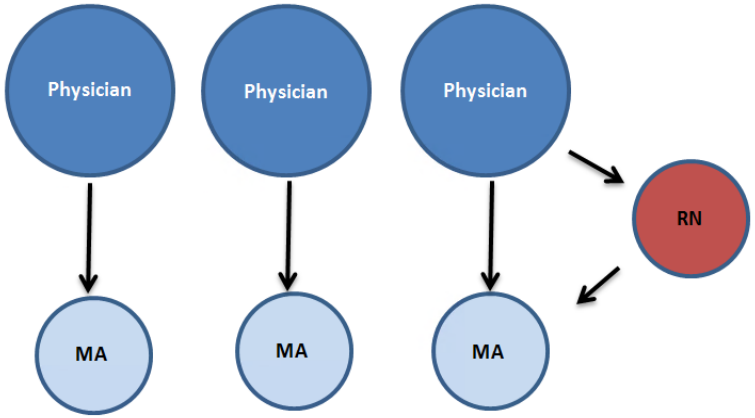
Those *most* in need of access may be the ones with the *least* ability to advocate for themselves

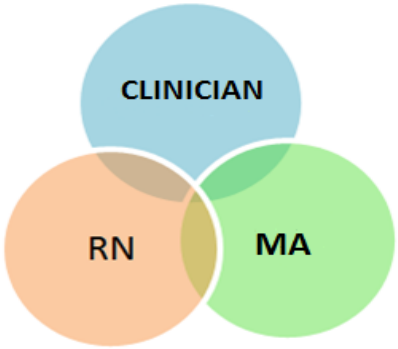
Consider a "Gold Card" program or active outreach to those at risk, especially following a transition of care from a hospital or ER

Develop a mechanism to recall patients with chronic conditions

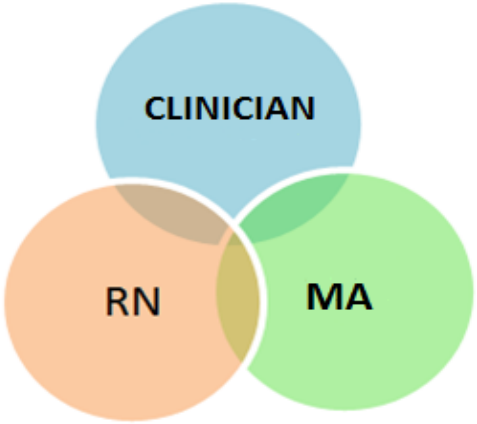
Primary Care Delivery

So Let's Re-Vision the Primary Care Team





Team Based Care



MD / DO / APRN / PA

Solves complex problems, defines care plans, leads the team

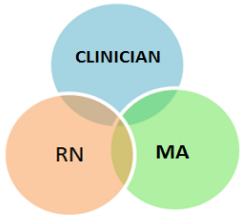
RN / LPN

Routine preventative services and population health management… Who is missing and why?

Medical Assistant

Screens for depression, anxiety, social determinants of health. Translates. Links patients to resources

Team Based Care



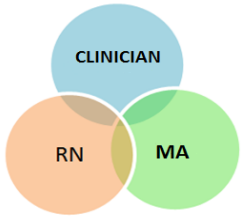
Take Home Lessons

Shift routine preventative services and disease-specific screenings to qualified staff (RN, LPN, pop-health specialists)

Create standing orders for routine screenings and processes

- **Cancer Screenings**
- **Adult and Pediatric vaccines**
- **A1c, Lipids, Hep C screening, and more**

Team Based Care



Take Home Lessons

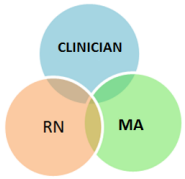
Train and retrain support staff (and your team leaders)

- Celebrate success
- Incentivize!

Recruit clinicians that fit your care model

- Team players
- Train in the team care model
- Foster collaboration
- Pay attention to team chemistry

Can Team Care Really Improve Quality?



Measure	2010 (pre team)	2014 (early team)	2017 (sustaining)	2019 (celebrating)
Peds Vax (CIS-10)	61%	68%	69%	71.9%
BP Control	59%	64%	65%	67%
A1c ≤ 8%	59%	61%	66%	67%
Colon Cancer Screening	30%	45%	50%	59%

Improved outcomes in a high-risk population
***Despite* significant barriers to care**

The Advanced Practice Medical Home

Patient Centered Medical Homes

If you were the customer, what would you want?

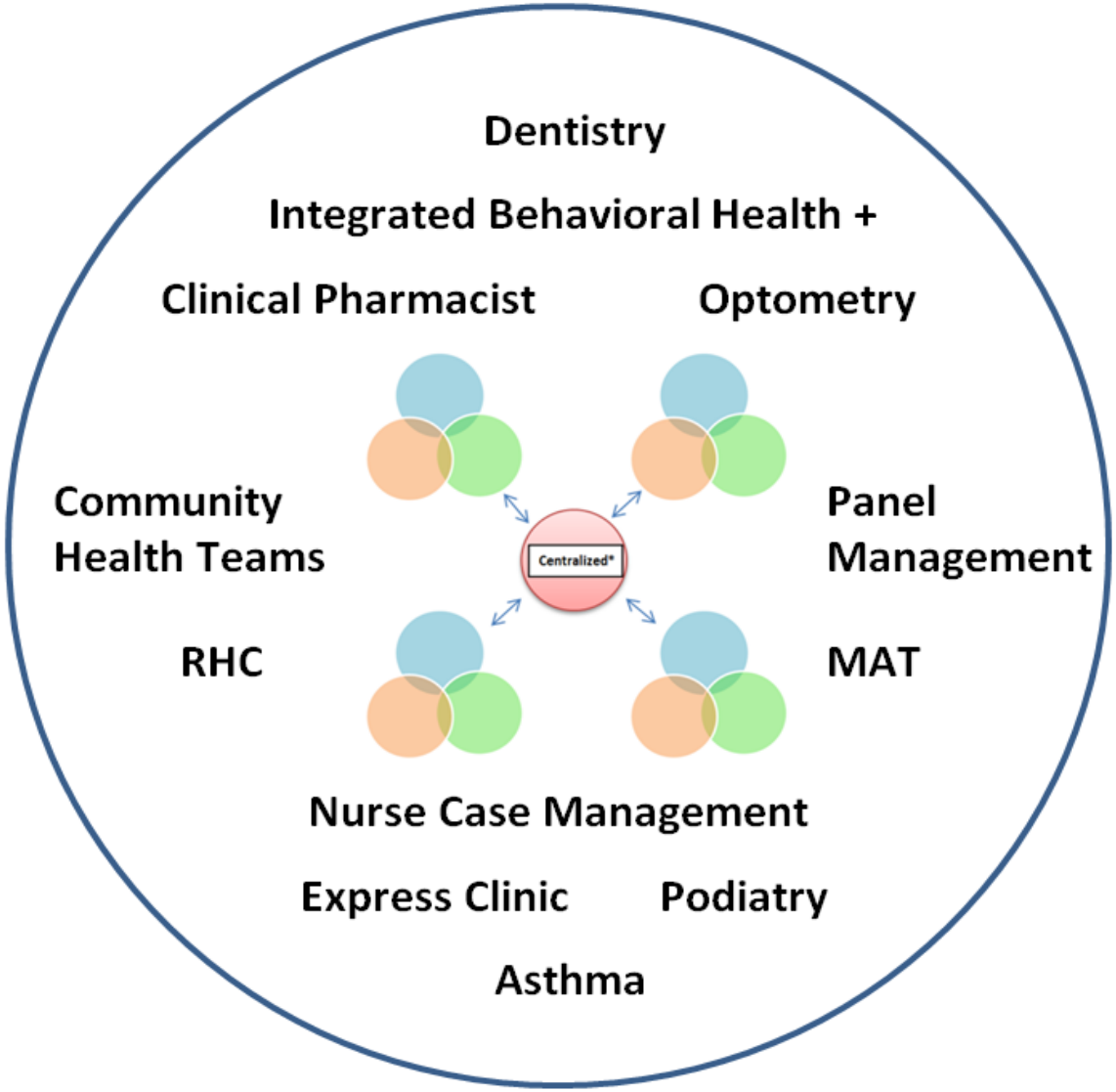
- Access when you want it
- Evening and weekend coverage
- Someone who understands you

Advanced Practice Medical Homes

To manage a population, what would you need?

- One-stop shopping
- Warm hand-offs
- Real-time or asynchronous consults in-house
- And the best practices we discuss here at CTC

Advanced Practice Medical Home at PCHC



IBH+ includes "Primary Care Psychiatry"
RHC= Reproductive Health Counselor
MAT = Medication Assisted Treatment Coordinated Program

Strategies Behind Our Success

Like most of our CTC colleagues, we rely on

- **Nurse Care Management**
  - **Target high utilizers**
  - **Transitions of Care**
- **Interdisciplinary Management of Highest Risk**
  - **IBH**
  - **Nurse Care Management**
  - **Primary Care Team**
- **Community Health Workers**
- **Clinical Pharmacy**

Strategies Behind Our Success

Why Host a Clinical Pharmacy Program?

Medicaid Dollar Expenditures

Long Term Care Facilities | Hospitals and Specialty | Pharmacy | Primary Care

Strategies Behind Our Success

But What Really Drives Our Success?

Integrated Behavioral Health!

Each clinical site has ***two*** IBH staff members:

- Led by an LICSW or PsyD
- Each with a Behavioral Health Advocate

Warm hand-offs are the goal… and incentivized

Virtual visits have been extraordinarily positive for both patients and the IBH clinicians

Why Screen?

Additional Costs When Someone with a Chronic Disease Also Has a Co-Occurring Mental Health Disorder

	PPPY Without MH	PPPY With MH	Cost of Co-Occurring Condition [10]
Heart Condition	$4,697	$6,919	**+ $2,222**
High Blood Pressure	$3,481	$5,492	**+ $2,011**
Asthma	$2,908	$4,028	**+ $1,120**
Diabetes	$4,172	$5,559	**+ $1,387**

10. Corso, K.A., Hunter, C.L., Dahl, O., Kallenberg, G.A and Manson, L. (2016) **Integrating Behavioral Health into the Medical Home: A Rapid Implementation Guide.** Greenbranch Publishing: Phoenix, MD

Strategies Behind Our Success

Universal Screening – part 1

- **Depression** (age 12 – 99)
- **Anxiety** (18+)
- **Substance Abuse** (18+)

Done at least once per year

During intake… now moving towards asynchronous

Standing orders encourage the care team to do a warm hand-off to IBH *before* the doc arrives

Screening Rates (whole pop) are tied to the incentive plans for the support staff

Strategies Behind Our Success

Universal Screening – part 2

- **Social Determinants of Health**

Standard HRA – modified for low literacy and culture

Performed at least once per year

During intake… now moving towards asynchronous

Screening Rates (whole pop) are tied to the incentive plans for support staff

Two types of responses when a need is identified:

- "Same day" needs routed to IBH team in clinic
- "Next day" needs routed to community health team

Strategies Behind Our Success

But simply screening is not enough.

What's your plan to deal with what you find?

Strategies Behind Our Success

COMPARING SDOH DATA PRE & DURING THE PANDEMIC

Cohort	Date Range	Unique Patients Screened	% Afraid of Harm	% Can't Afford Meds	% Food Insecurity	% Housing Insecurity	% Living Conditions Impact Health	% No Transportation	% Utility Shut-Off	% Yes To One	% Would Like Assistance
Pre-Covid	2019-05-01 through 2019-12-31	19,698	0.52%	1.06%	**1.65%**	1.36%	1.03%	0.96%	0.96%	4.29%	27.22%
During Pandemic	2020-03-16 through 2020-12-29	24,756	1.16%	2.23%	**5.72%**	4.06%	2.26%	2.27%	2.27%	10.75%	43.43%

SDOH Factor	Mitigation Strategy
Housing	Rental assistance programs, Covid-19 relief funds, supportive housing program, Center for Justice
Transportation	Round Trip, MTM
Utilities	Low-Income Energy Assistance program, Covid-19 relief funds
Food	Food boxes, meal delivery, applying for SNAP/WIC, Farm Fresh RI Produce Rx program, grocery shopping assistance with Center for Southeast Asians
Finances	Gift cards, donations, Covid-19 relief funds

4

Strategies Behind Our Success

Actively Screen and Address the Social Determinants

PCHC partners with

- Family Services of Rhode Island
- Rhode Island Food Bank
- Farm Fresh Rhode Island
- One Neighborhood Builders
- Medical Legal Partnership of Boston
- Center for Justice
- Center for Southeast Asians
- House of Hope
- And *many* others

Strategies Behind Our Success

USING DATA TO ADDRESS FOOD INSECURITY

- Outreach to COVID+ patients experiencing food insecurity and connect them with resources
- Prioritize outreach for food assistance programs to those experiencing food insecurity

Tools developed

- Food Assessment (April 2020)
- Food Assistance Referral Tracking (Oct 2020)

Results

- 40 SNAP applications completed with CHA
- 27 Gift cards delivered to patients
- Purchased and delivered groceries to 75 families
- 700 food boxes delivered to families
- 344 food assistance referrals sent to CBOs

6

Strategies Behind Our Success

Community Health Workers are One of the Most Cost-Effective Public Health Strategies

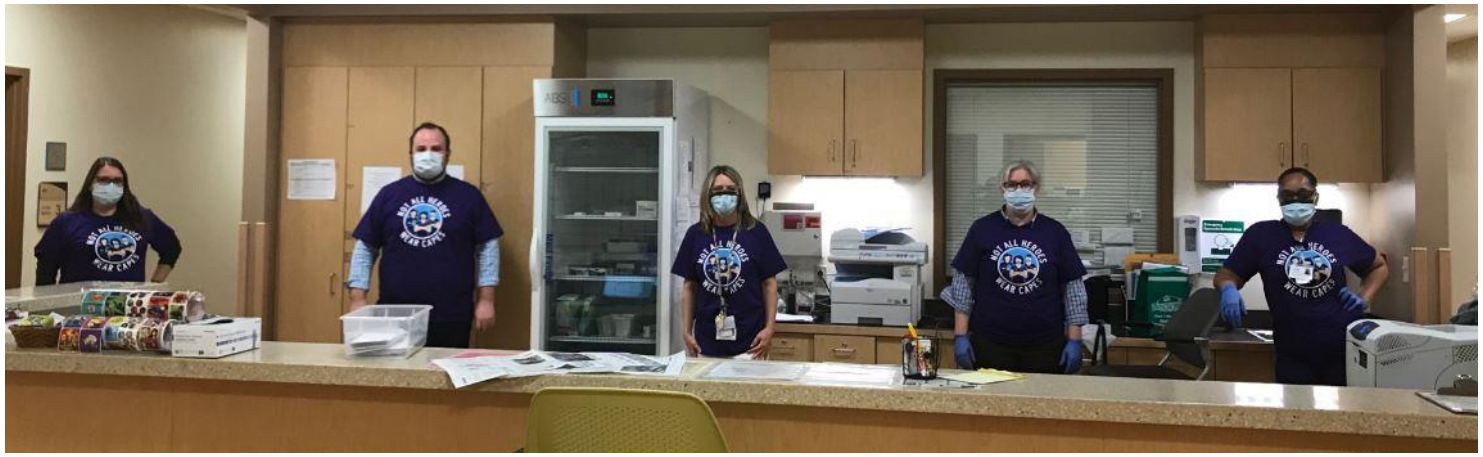
Strategies Behind Our Success

Express Care

Increased Access… *and More*

Goal = Reducing Unnecessary ER Utilization

- **Broad scope of care including IV fluids, X-ray**
- **1 Family physician with 2+ NPs, 7 days per week**
- **Rapid testing - now including the "ILI triple play"**
- **5 Negative pressure rooms with separate entrance**



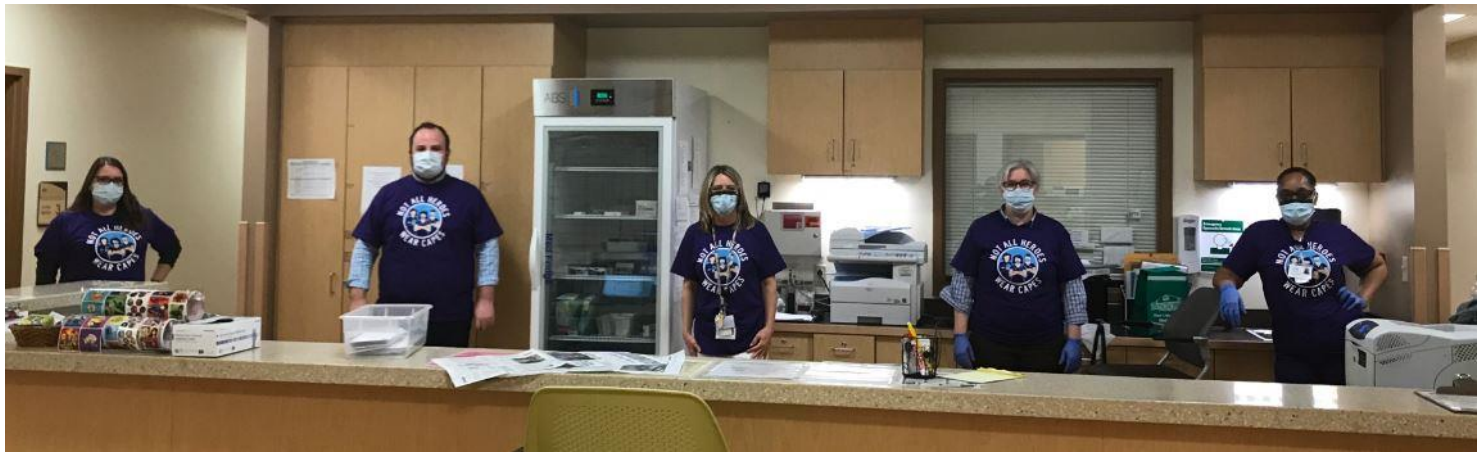
Strategies Behind Our Success

Express Care

Increased Access… *and More*

Goal = Reducing Unnecessary ER Utilization

- **IBH available for warm hand-offs on weekdays**
- **25,000 visits per year and growing**
- **Enhanced relationship with Providence Fire for 911**
  - **Not Outbound… Inbound**



MOBILE HEALTH INITIATIVE

PCHC and the City of Providence collaborate on the Mobile Health Initiative

NBC 10 I-Team: Mobile unit aimed at reducing unnecessary ER visits

by KATIE DAVIS, NBC 10 NEWS | Tuesday, October 22nd 2019

The City of Providence has a plan to free up rescue units for real emergencies. (WJAR)

https://turnto10.com/i-team/nbc-10-i-team-mobile-unit-aimed-at-reducing-unnecessary-er-visits

Strategies Behind Our Success

Specialty Clinics

Physical *and* Virtual

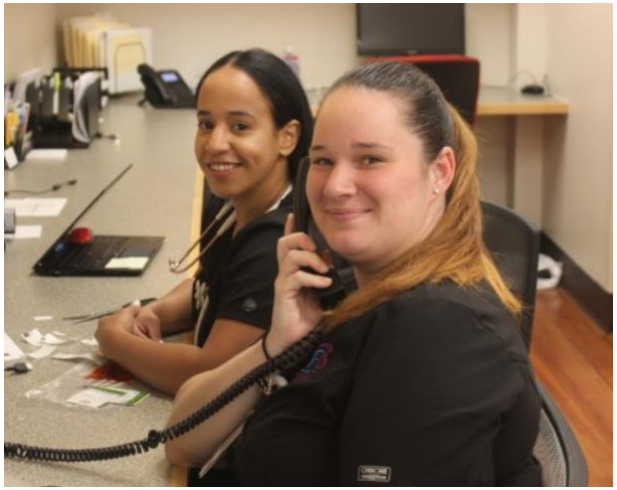
Many are salaried clinicians of PCHC

Others are sub-contracted specialists

All on same EHR and Skype platform

With Care Coordination built-in

Active Referrals Management



Strategies Behind Our Success

In-House Specialties at PCHC

Asthma / Allergy

Optometry

Podiatry

Dermatology

Nephrology

“Primary Care” Psychiatry

Medication Assisted Treatment

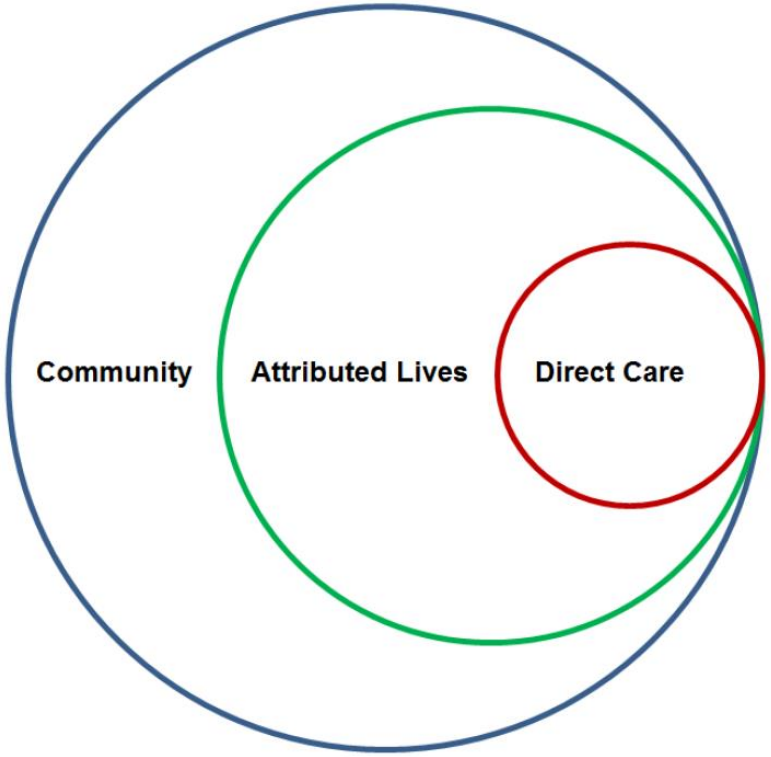
Reproductive Health Counselors

Hepatitis C and Latent TB Treatment

One-Stop Shopping

Population Health 101

Remember the Big Picture



Recognize your Spheres of Influence…
And Remember the Serenity Prayer

So How Will We Know If It's Working?

Happy Patients

Better Outcomes

Lower Cost

Happy Care Teams

So How Will We Know It's Working?

Proudly Serving Providence Since 1968

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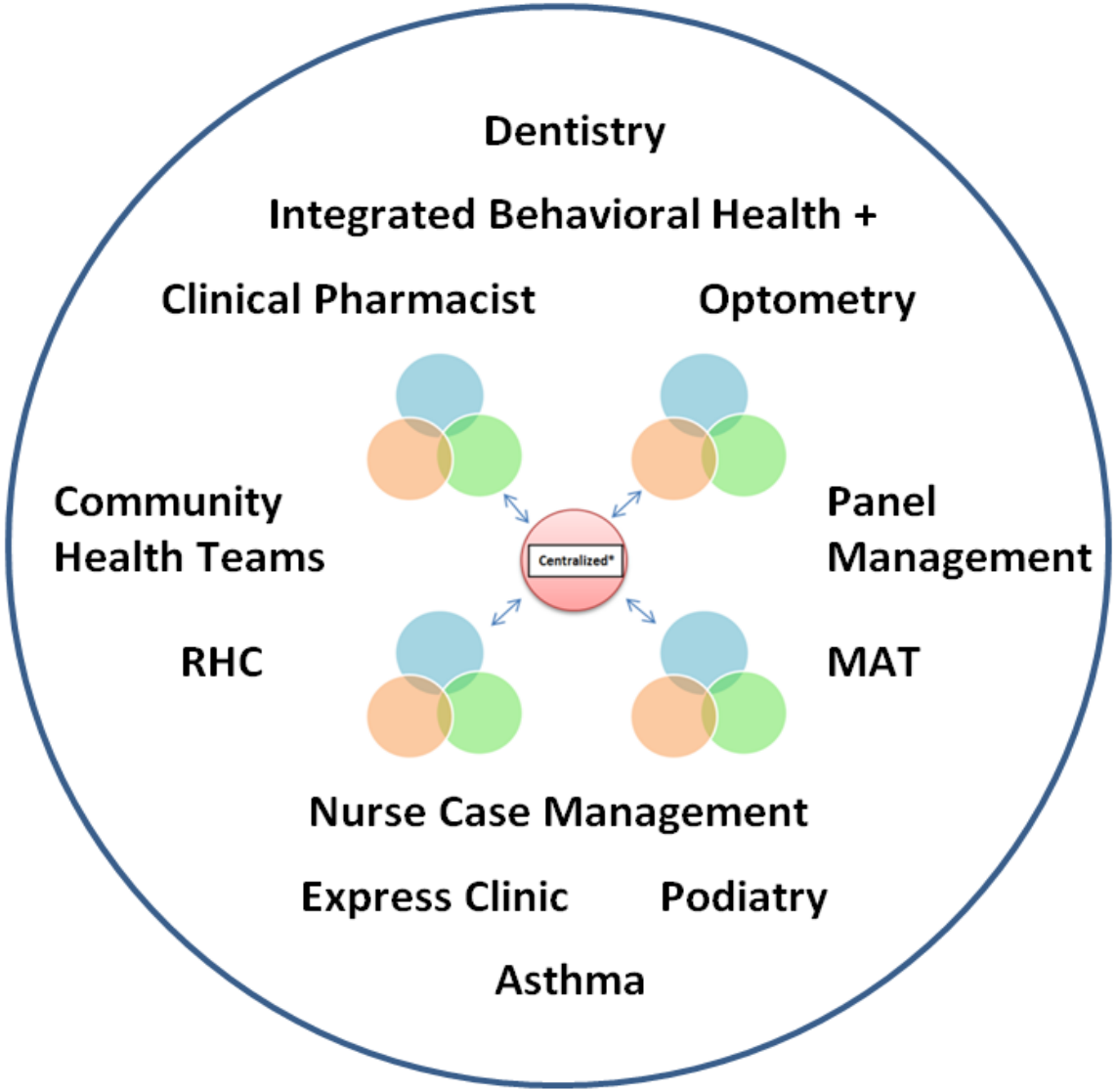
Advanced Practice Medical Home at PCHC



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