The Lebanon Medical Home Clinic "Partners in Care"

Presented to

The Oregon Rural Health Conference – 2012

Rick Wopat, MD

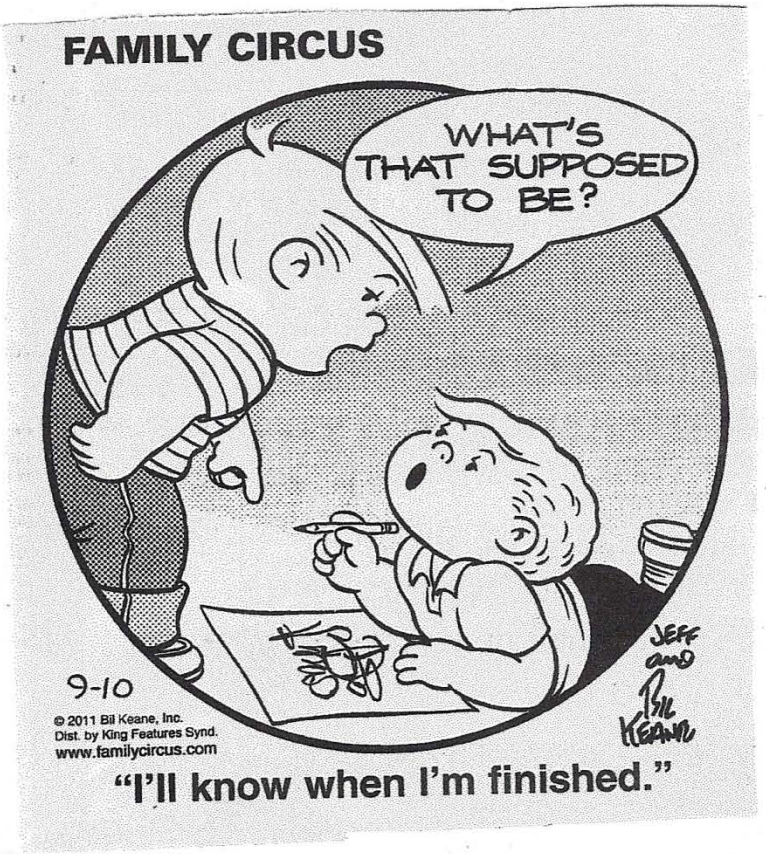
Environmental Engineer

Plan For Today

- Have a dialogue
- Review the set up in the Samaritan Lebanon Medical Home Clinic
- Discuss what I would consider successes
- Discuss ongoing challenges

What is "The Medical Home"

Defining the "Medical Home"



The Space

- 3 provider's offices – we do not use them for offices but for consultation rooms.
- 5 exam rooms
- 1 procedure room
- The 'fish bowl" – 6 desks for care providers in a 20 x 9 foot space
- The front desk
- The group room / education room/ 'waiting area'

The Team

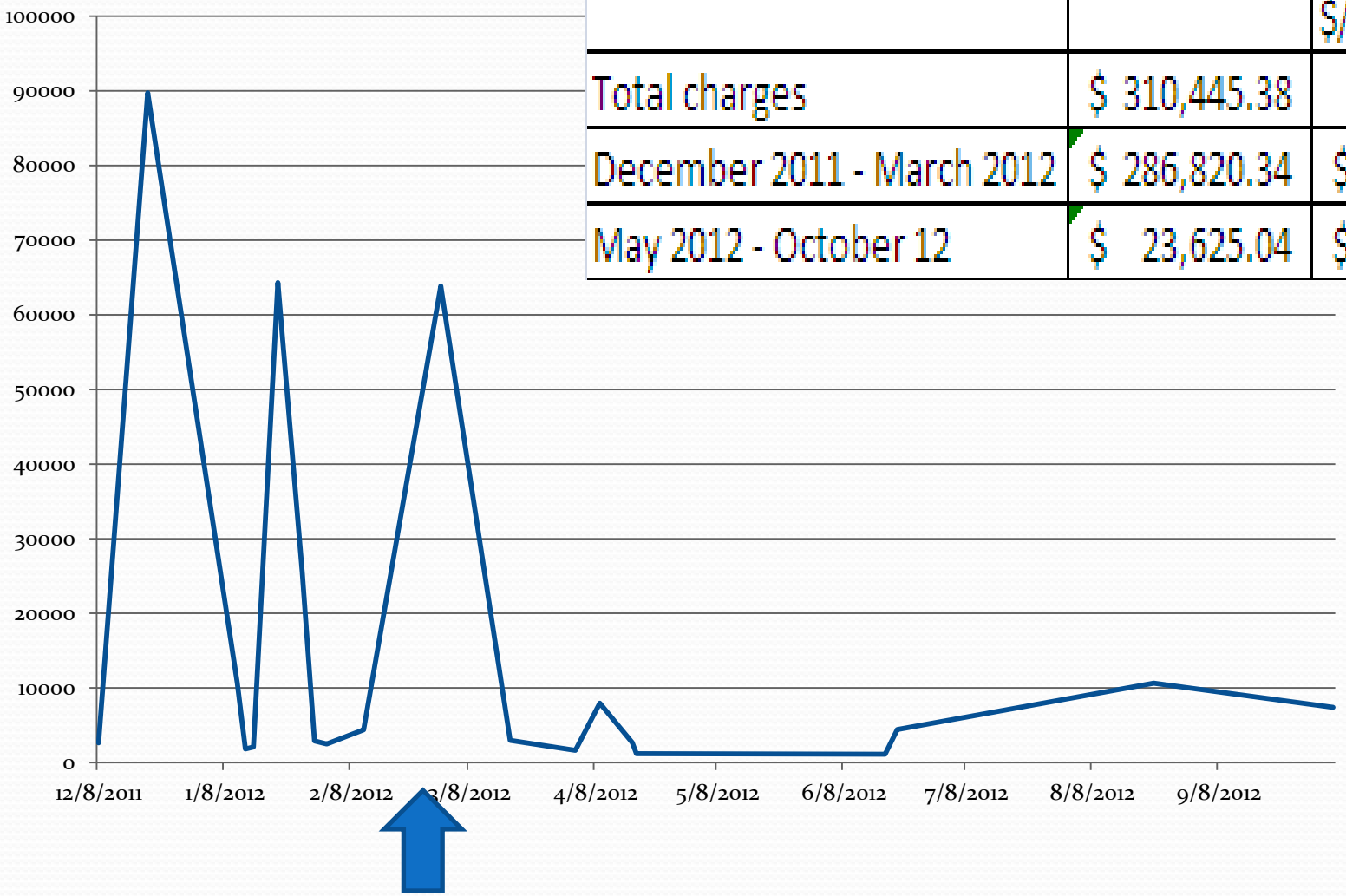
- 1 FTE family physician
  - 4 days a week patient visits
  - 1 day a week for paper work and home visits/nursing home visits
- 0.4 FTE family nurse practitioner
- 1.5 certified medical assistants
- 1.0 FTE "Case Manager"
  - Back up everything - CMA, receptionist
- 0.5 FTE Psychology resident
- 0.5 FTE "Tobacco free" counselor
- 0.1 Drug and Alcohol intake counselor who is an employee of Emergence
- 1.0 FTE OHSU medical student

Team Members I am pursuing

- Pharmacist – a pharmacist a day a week
  - Many patients come to me with multiple chronic conditions and on 10-20 (or more) chronic medications
  - Medication simplification and medication reconciliation takes a lot of time and effort
- Psychiatrist – either on site or by video contact
  - Many patients have significant chronic mental health conditions and are on multiple mental health drugs
- Community health workers
  - To go into the community and patients homes to assist patients
- Peer counselors

Sherry C. - Hospital and ED charges

		$/month
Total charges	$ 310,445.38	
December 2011 - March 2012	$ 286,820.34	$57,364.07
May 2012 - October 12	$ 23,625.04	$ 3,937.51



And The Others

- Ryan D.
- Julie S.
- David H.
- Debbie S.
- Carrie H.
- Erin H.
- Roberta Jean
- Marianne S.
- Billy Ray
- Michael P.
- Nick and Teresa
- Edna
- Eva and Bill
- Paul and Mary
- Paul

Our goals

- congruent with the triple aim
  - support patients in staying healthy and getting healthy
    - built in preventive care services
    - self management of chronic conditions such as hypertension, diabetes and asthma
    - group visits for diabetes and chronic pain
  - improving the experience of care
    - access and service
    - co-location of support services – counseling and care coordination

Our goals

- congruent with the triple aim
  - reducing per capita costs
    - We work to reduce unnecessary office visits by optimizing patient self management through
      - Self monitoring and reporting – diabetes, blood pressure, asthma
      - Manage medication changes by phone and e-mail
      - Review our schedule a day ahead and see what patients **we do not need to see**
      - ED and UC visits are reviewed and patients contacted where care could have been provided in the ED
      - hospitalizations are reviewed and discharge planning is coordinated with our staff

Changes in Process

- Weekly staff meetings to review procedures
- Quarterly day long ‘retreats’ to look at how we could do it differently
- Keep our daily patient visits about 10 visits and under 15 / day so we can spend the time needed with every patient
- New patients get 60 – 90 minutes and we attempt to do complete evaluations the first visit.
- Established patients get 20-40 minute visits where we attempt to address all of their concerns at one visit
- See patients the same day or the next day for acute concerns so they do not need to wait. We keep open about 25 -30 % if the schedule every days so we can see urgent visits.

Changes in Process

- We do “warm handoffs” to the psychologist, case manager, tobacco free counselor or drug and alcohol counselor whenever possible.
- We do not “fire” patients but put them on coordinated treatment plans with progressive interventions
  - We require patients with potential drug or alcohol problems to be evaluated by the Emergence staff and may require treatment to maintain a relationship where we will prescribe for them.
- We have daily “huddles” about patient care and weekly “patient care coordination conferences” to develop coordinated care plans.
- We make team house calls and nursing home visits on Wednesdays when needed.

Successes

- Reductions in hospitalizations and ED and UC visits
- Individual patient successes
- Team development
- Individual development within the team
- Improvement in immediate access and reduction of “routine” follow up
- Empowering self management
- Group visits

Challenges –System Wide

- Misalignment of incentives and direction
  - Fee for service
  - Physician compensation
  - No “reward” to PCPs for coordination of care
  - Specialty physicians are not incented to coordinate care
  - Hospitals have been considered “income centers” in the past but will be “cost centers” to the CCOs
- We do not have adequate data to drive change
- We have trouble tracking patients and coordinating care

Practice Challenges

- Increasing complex patients - each with individual needs
  - Multiple chronic conditions
  - Co-morbid mental health and substance abuse
  - Advanced age of patients
- We need a differently designed “space” in which to work
- Having the “right” staff to do what needs to be done
- Empowering and encouraging staff to act independently
- Improving coordination of care with
  - Hospital care staff
  - County mental health
  - Nursing home staff
  - Specialty care physicians

"Wish List"

- More mental health services "on the ground"
  - Co-location and use of electronic communications
- More structured drug and alcohol treatment programs at the local level.
- More "community health workers" to work with patients to help with complex psycho-social management issues
- Community health support for our elderly and disabled patients to get them the things they need to avoid unnecessary injuries and hospitalizations.
- More medication management support to make sure that patients are using their medications correctly
- Less paper

What the Future Looks Like

"The best way to predict the future is to invent it."

- Alan Kay 1971

(Early pioneer in computers , credited with inventing the laptop and "windowing" technology)