

# ADVANCED PRIMARY CARE: PRINCIPLES, PARTNERSHIPS, AND PRACTICE

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# Objectives

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- Understand the core concepts of the “advanced primary care home” for people experiencing homelessness
- Consider 3 components of an advanced primary care home:
  - ▣ Advanced Medication Management
  - ▣ Integrated Addictions
  - ▣ Care Transitions
- Explore further opportunities for strategic partnerships in development of the advanced primary care home

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# Framework and Core Concepts

# Definitions of Advanced Primary Care

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- Home/ Community Based - outreach
- Freestanding: care transferred from regular primary care setting to high-intensity clinics
- Practice – based: high-intensity inter-disciplinary services added to regular primary care

Peterson K. **Evidence Brief: Effectiveness of Intensive Primary Care Programs**, VA-ESP; 2013

# Who We Are

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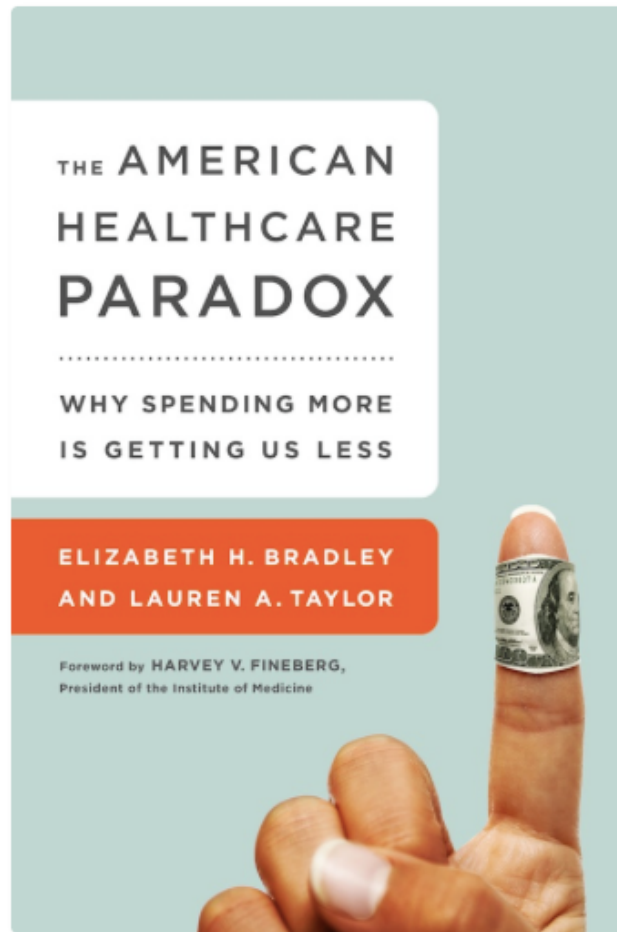


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# Shifting Concepts for Partnerships

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Bradley, Taylor, PublicAffairs, 2013

# Core Concepts in Advanced Primary Care

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## The What:

- Care Management
- Advanced medication management
- Managing transitions of care
- Integrated behavioral health
- Outreach services and intensive case mgmt
- Enhanced self-management support
- Proactive care planning
- Population approach





# Core Concepts in Advanced Primary Care

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## The Who:

- Interdisciplinary teams (pharmacy, addictions, CHW's, OT/PT)
- Intentional relationships with peer supports & mentors who can best facilitate individual transformation
- Community partnerships that extend beyond medical services to behavioral/ social services, tertiary care centers, academic institutions





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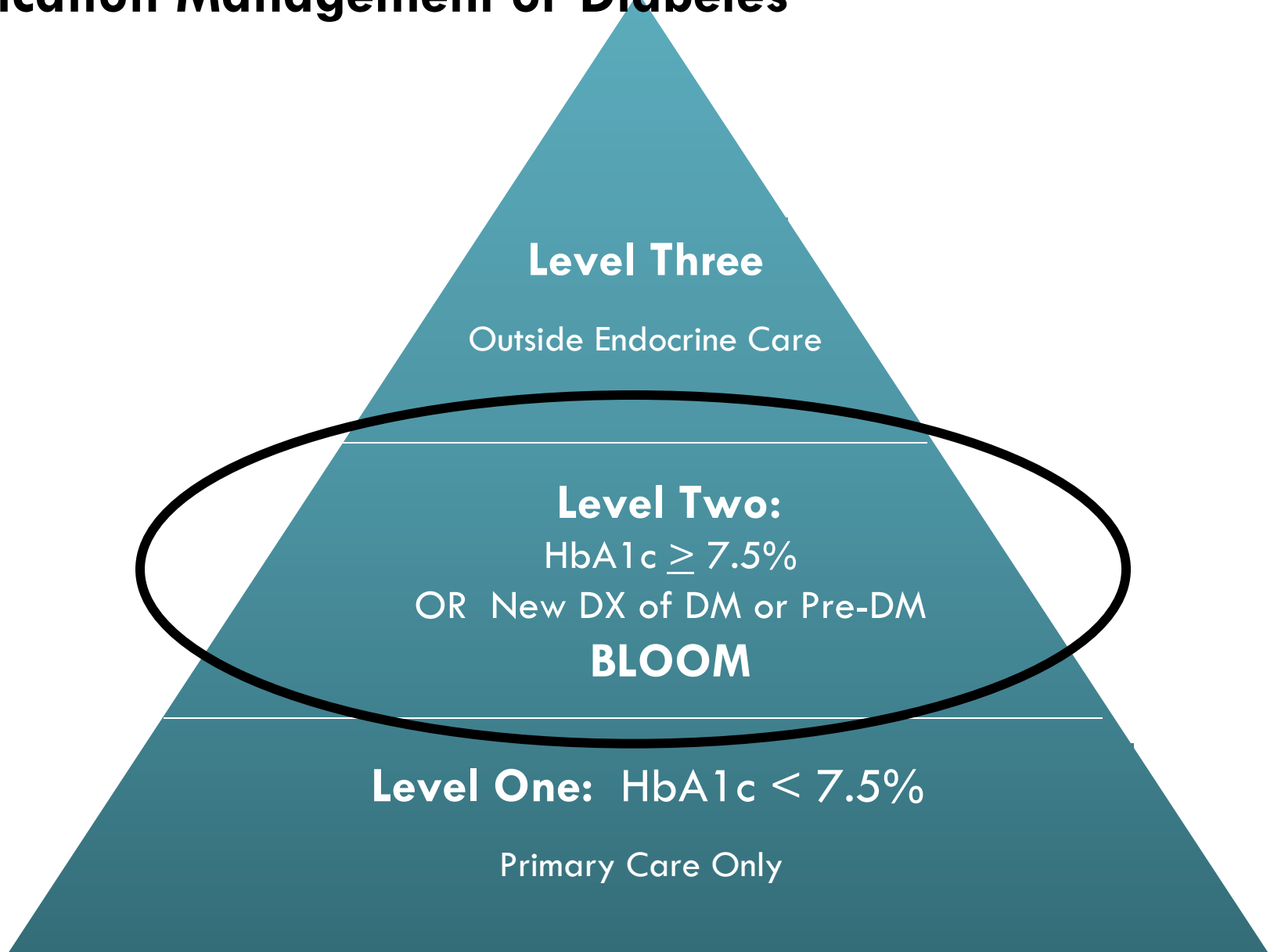
# Advanced Medication Management

# Diabetes Management: BLOOM

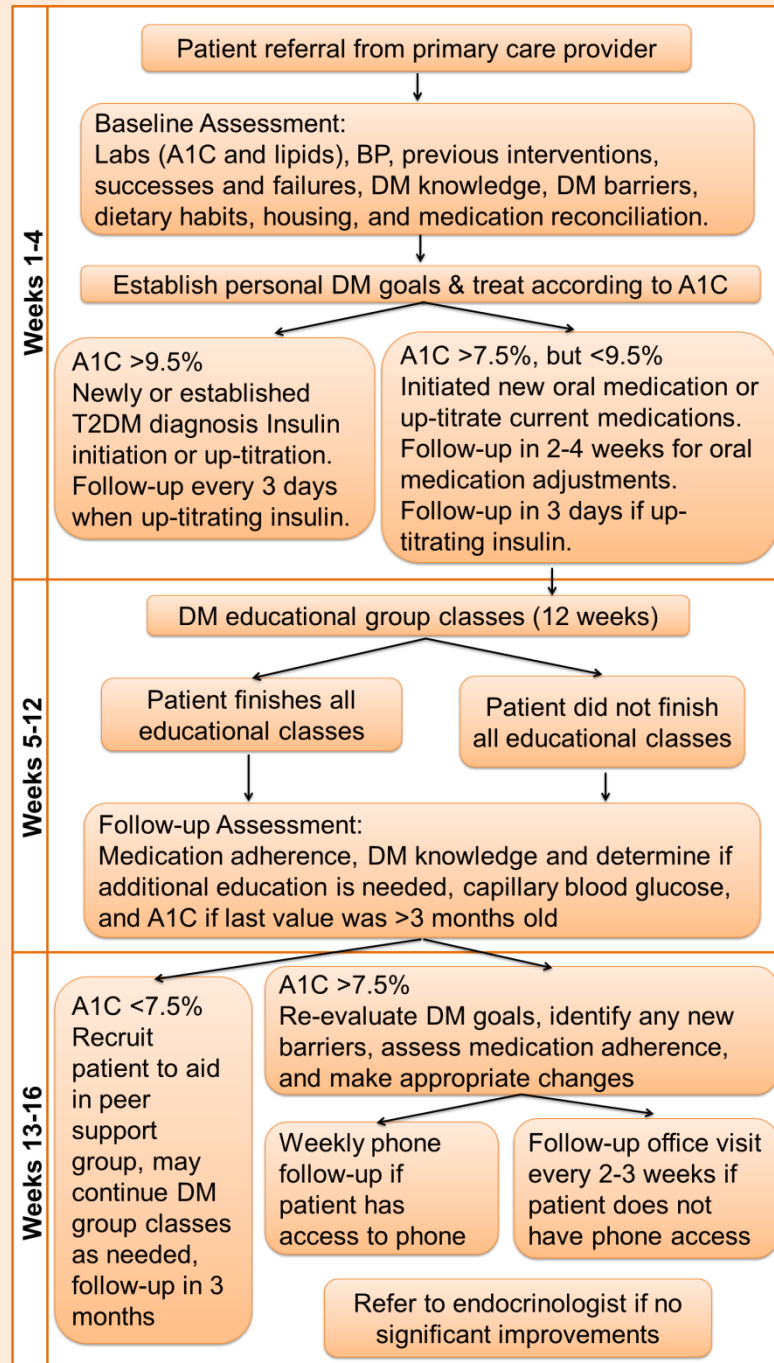
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- ❑ High prevalence of DM-related emergency department visits and poorly controlled diabetes
- ❑ Need for rigorous, intensive medication management with attention to barriers such as addiction, mental health comorbidities, lack of safe place to store medications, and inability to coordinate medications with meals
- ❑ Partnership with OHSU/OSU College of Pharmacy to embed 2 Pharm D's in Old Town Clinic

# Risk Stratification Method for Medication Management of Diabetes



**Figure 1. Overview of DM Program Activities**



# RESULTS

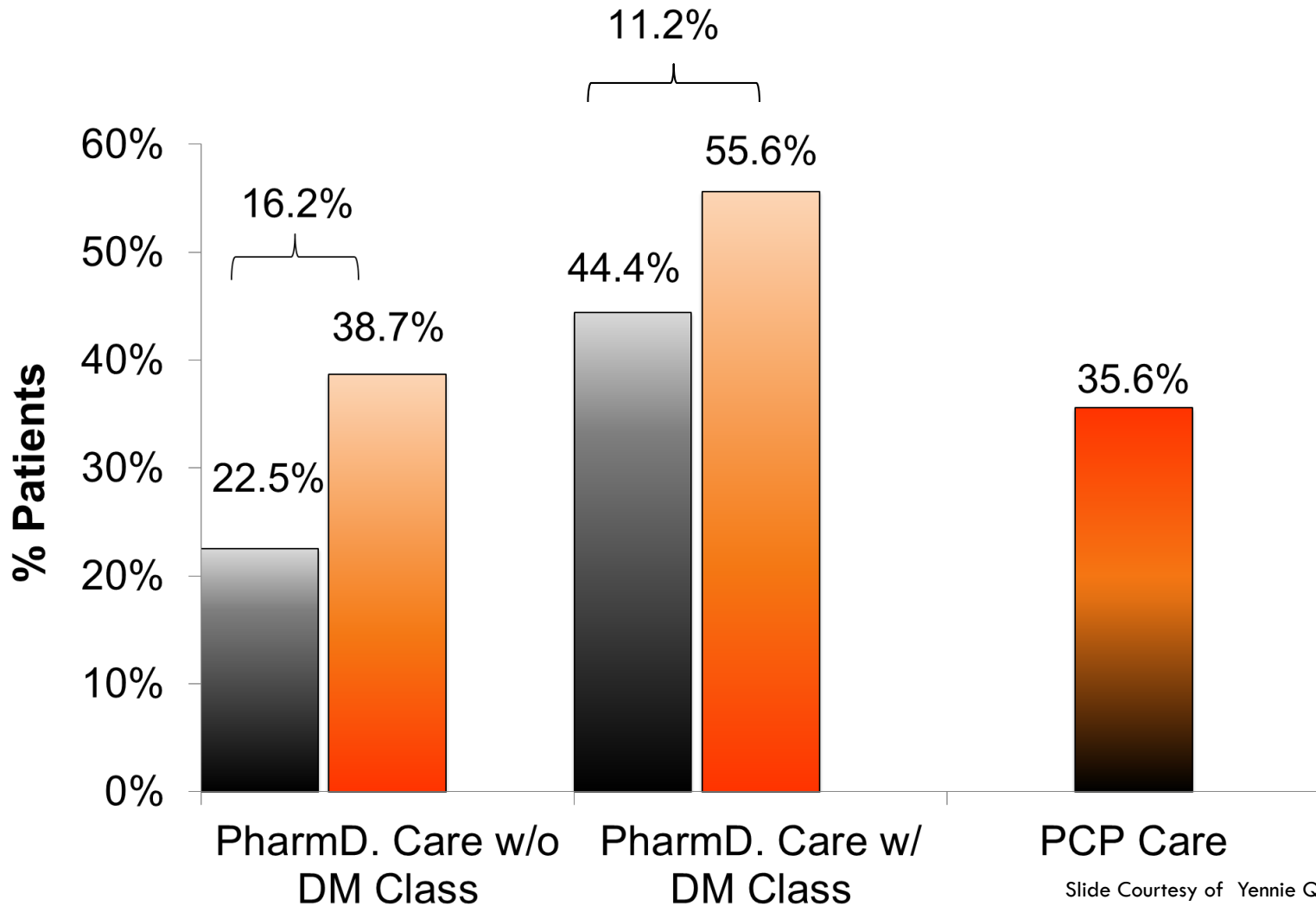
**Table 1. Baseline Characteristics**

<b>Characteristics</b>	<b>Study Group (N=40)</b>
Age (yr)	53.7 ± 8.3
Male	19 (47.5%)
<b>Race or ethnicity</b>	
African American	9 (22.5%)
Caucasian	22 (55%)
Hispanic	7 (17.5%)
Native American	2 (5%)
<b>Lab Values</b>	
<b>Mean Values</b>	
A1C (%)	9.5% ± 2.4%
LDL (mg/dL)	111.7 ± 39.9
Systolic BP (mmHg)	127 ± 17.8
Diastolic BP (mmHg)	77.7 ± 13
<b>Comorbidities</b>	
Coronary Artery Disease	8 (20%)
Dyslipidemia	22 (55%)
Hypertension	19 (47.5%)
Bipolar	7 (17.5%)
Major Depressive Disorder	19 (47.5%)
Schizophrenia	5 (12.5%)
Substance Abuse	18 (45%)
<b>Treatment</b>	
Oral medication only	16 (41%)
Insulin only	2 (5.1%)
Oral medication and insulin	21 (53.8%)
<b>Filling Pharmacy</b>	
Central City Concern	30 (75%)

Slide Courtesy of Yennie Quach PharmD and Michael Daher PharmD

## Figure 2. Frequency of Patients at A1C Goal

■ Baseline    ■ >3 Mo. Follow-Up    ■ Not Enrolled in Program



Slide Courtesy of Yennie Quach PharmD and Michael Daher PharmD

# Summary

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- ❖ A higher percentage of patients enrolled in the pharmacist-managed DM program met A1C goal compared to standard PCP care
- ❖ Strategies such as appointment reminders, walk-in appointments, flexible scheduling, assistance with housing and food, daily medication dispense, and frequent follow-ups contributed to the success in managing DM in this complex population



# Next Steps

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- ❖ Future interventions include pharmacist-managed programs for congestive heart failure, hypertension and hyperlipidemia
- ❖ Aim to measure health system outcomes such as ED utilization, hospital admissions and readmissions

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# Integrated Addictions

# Prevalence of Select Conditions Among Old Town Clinic Patients

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Condition	# of patients	Prevalence
Alcohol dependence	447	12%
Alcohol abuse	708	20%
Bipolar	279	8%
COPD	555	15%
Diabetes	653	18%
Drug dependence	985	27%
Drug abuse	639	18%
Hep C	859	24%
Hypertension	1240	35%
Major depression	1033	29%
Personality disorder	163	5%
PTSD	873	24%
Schizophrenia	542	15%

# A&D Treatment at Old Town Clinic

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- Old Town Clinic licensed as A&D site to provide “Level One” services on-site in primary care with two CADC’s and two Health Educators
- Services include:
  - ▣ Interventions with with “Risky, Harmful, and Dependent” scoring patients via SBIRT
  - ▣ ASAM Assessments
  - ▣ Provide Level One alcohol and drug treatment groups
    - “Hot Sauce” group for patients at risk of full relapse on opiates for chronic pain.
    - Twice weekly group and individual treatment for patients on suboxone
    - Weekly groups for people with other SUDs

# A&D Treatment at Old Town Clinic

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- “Hot Hand Offs” for Dependent patients in planning and action stages of change
  - Connect from primary care to subacute detox and follow up
  - Connect from primary care to specialty alcohol and drug treatment services
- Controlled Substance Review committee

# Benefits and Risks of Integrated A&D

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- **Benefits:**
  - ▣ Higher rate of engagement and treatment completion
  - ▣ Maximizes members of team, increases panel size
  - ▣ Improves addictions knowledge of primary care team
- **Risks:**
  - ▣ No housing attached to these programs
  - ▣ Difficult to coordinate with hospital for high risk patients

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# Care Transitions Innovation (C-Train)

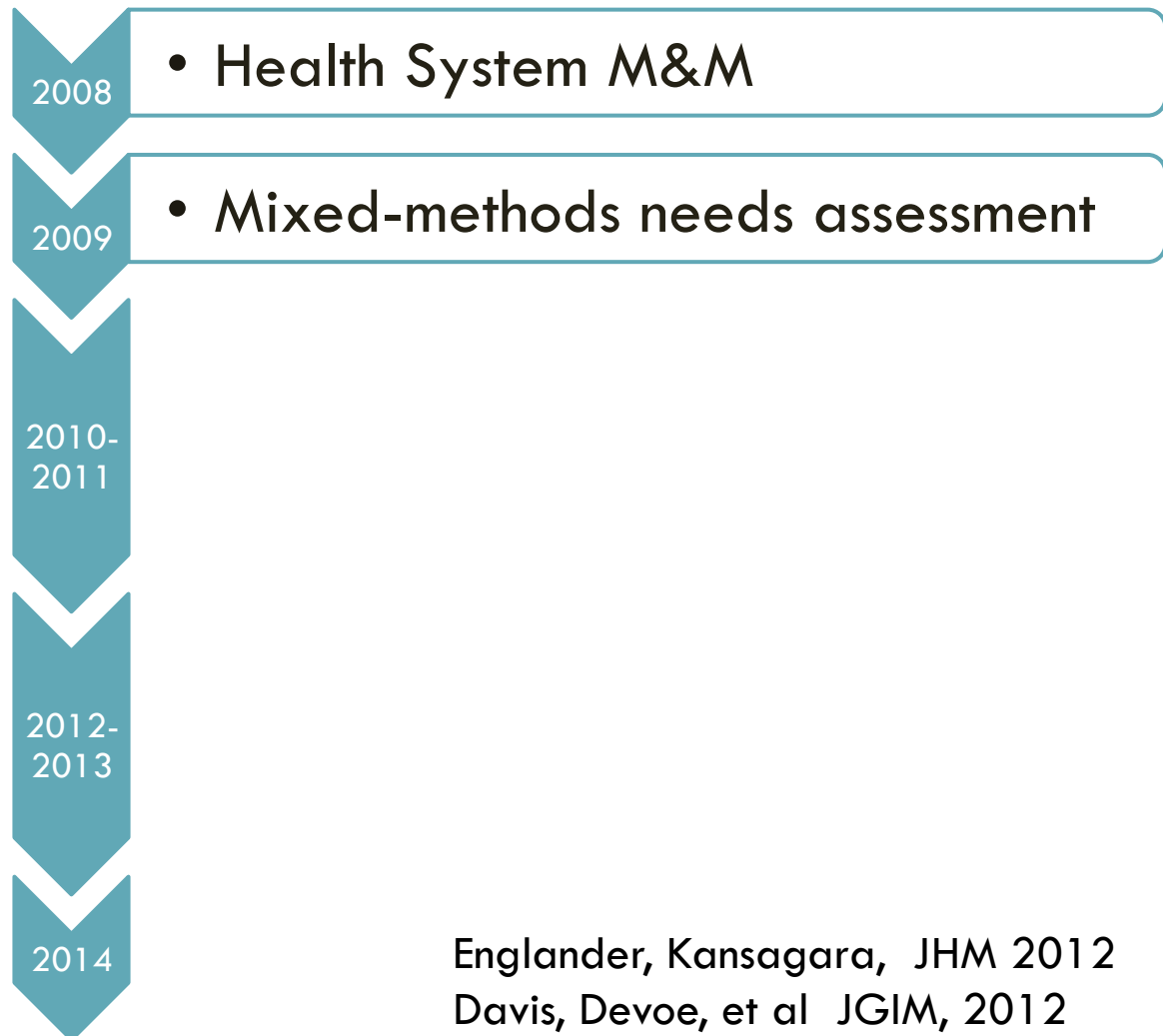
11/12/2010



# PATIENT NARRATIVE SPARKS HOSPITAL CHANGE



# C-Train Development



# Complex medical and social needs

	Uninsured n = 43	Medicaid n = 51
Lack usual source of care (%)	33.3	11.1*
Low Health literacy (%)	41.5	41.7
Barriers to taking meds as prescribed (%)	42.9	21.6*
Cost of meds as leading barrier (%)	30.0	2.9*
Co-morbid depression (%)	54.8	45.9
Marginal Housing (%)	40.5	32.4

# C-Train Development



# Needs Map to C-Train Components

**Self-  
management  
difficult**

C-Train Nurse

**Medications  
complex, costly**

Inpatient  
Pharmacy  
Consult

C-Train  
Formulary

**Many barriers  
to outpatient  
care**

Medical  
Home  
Partnerships

**Silos of Care**

Monthly  
cross-site  
meetings

# C-TRAIN Cluster RCT

- Uninsured and Medicaid adults
  - ▣ admitted to medicine, cardiology
  - ▣ residing in tri-county area
  - ▣ access to working phone (friend/ message ok)
  
- Statewide hospital discharge data and patient surveys
  - ▣ 30-day readmission and ED use
  - ▣ transitional care quality and patient experience

# Results

- Enrolled 382 patients (209 C-Train; 173 control)
- 283 (74%) reached by telephone 30d post-discharge
  
- Process measures
  - ▣ 93% had inpatient pharmacy consult
  - ▣ 78% had at least 1 nurse follow up call
  - ▣ 50% had a nurse home visit after discharge
  - ▣ 69% uninsured and 17% publicly uninsured had a new primary care linkage
  
- Monthly cross-site, multidisciplinary meetings springboard for local systems change



# C-Train Improved Quality

Outcome	C-Train	Usual Care	OR (95% CI)	Adjusted OR (95% CI)
<b>CTM-3 above median (n)</b>	<b>47.3% (71/150)</b>	<b>30.3% (36/119)</b>	<b>OR 2.2 (1.3–3.6)</b>	<b>OR 2.4 (1.4–4.1)</b>
• Patient preferences considered (strongly agree)	37.3% (56/150)	18.5% (22/119)	OR 2.75 (1.54–4.91)	OR 3.06 (1.66–5.63)
• Self-management understanding (strongly agree)	36.0% (54/150)	24.4% (29/119)	OR 1.76 (1.03–3.02)	OR 1.87 (1.06–3.32)
• Medication understanding (strongly agree)	36.7% (55/150)	27.7% (33/119)	OR 1.55 (0.91–2.62)	OR 1.60 (0.92–2.78)

# No difference in 30-day readmission and ED use

Outcome	C-TraIn	Usual Care	OR (95% CI)	Adjusted* OR (95% CI)
<b>Readmission within 30 days (n)</b>	14.4% (30/209)	16.1% (27/168)	OR 0.88 (0.50–1.54)	<b>OR 0.88</b> <b>(0.49-1.59)</b>
<b>ED visit within 30 days (n)</b>	24.4% (51/209)	19.6% (33/168)	OR 1.32 (0.81–2.17)	<b>OR 1.38</b> <b>(0.83-2.31)</b>

\*Adjusted for age, gender, Charlson comorbidity index, and patient-level clustering

# Teams identified many patient and system-levels gaps



# C-Train Development

## Policies over time

03/10: ACA becomes law;  
Readmission penalties  
announced

3/12: Oregon CCO waiver

07/12: CMMI grant funded

08/12: CTM-3 added to  
HCAHPS

01/13: Transitional Care  
Codes in Primary care

Late 2014: CTM-3 to be  
publicly reported

2008

- Health System M&M

2009

- Mixed-methods needs assessment
- Engaged community stakeholders

2010-  
2011

- C-TRAIN RCT

2012-  
2013

- Spread to OHSU, Legacy Hospitals

2014

- Further integration

# Implications and Lessons Learned

- Policy creates incentive for integration
- Importance of readmission and quality measures
- Hospitals increasingly recognize value of shifting care into community settings
  - ▣ Focus on transitions opens doors for broader collaboration

# Implications and Lessons Learned

- Lessons from vulnerable population scalable across hospital systems
- Gaps in transitional care highlight needs across the care continuum
  - ▣ Integration of addictions services across settings
  - ▣ Primary care capacity to manage complex patients

# Strategic Partnerships

To support an Advanced Primary Care home

# Incentives across settings

## Hospital drivers

- ↓ Readmissions and ED use
- ↑ bed capacity
- Lower costs
- Manage risk in ACO era
- Improve population health

Strategic Partners

## HCH drivers

- ↓ Admissions and ED use
- ↑ primary care capacity
- ↑ specialty care access
- ↑ housing
- Improve population health



# Emerging conversations

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- Population health for patients with substance use disorders
  - ▣ Pathways of care from hospital to community
  - ▣ Increased expertise in hospital for managing SUD
  - ▣ Access to specialty care for patients whose SUD is exacerbated by untreated medical conditions
  - ▣ Support for short-term housing subsidies for people engaging in outpatient addictions treatment

# Risks

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- Alignment can get hazy
- Environment contains multiple hospitals, clinics, payers
- Payers' role uncertain
- Adverse selection could lead to disincentives for hospital partners
- Cross-site challenges of EMRs, leadership, culture

# Thank you

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