OPCA

Oregon Primary Care Association

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Welcome to the APCM LEARNING SESSION

January 25th, 2018

Are you on Twitter or Facebook?

If you feel inspired to post on social media about this APCM Learning Session, use **#OregonAPCM** or **#OregonCHCs** and tag OPCA **@OregonPCA**


WASHINGTON PARK
Rose Garden
Japanese Garden
Hoyt Arboretum
World Forestry Center
Oregon Zoo
Children s Museum

Learn who's in the room!

Health Centers

Phase 1 - March 2013	Phase 2 – July 2014	Phase 3 – July 2015	Phase 4 – July 2016	Phase 5 – July 2017	Phase 6 – July 2018
Mosaic Medical	Benton County	Clackamas County	Neighborhood	La Clinica	Lane County
OHSU-Richmond	Multnomah County	Rinehart	NWHS	Wallace	Valley Family
Virginia Garcia	OHSU-Scappoose	Rogue	Winding Waters		
	Yakima Valley				

Columbia River Community Health Services

Funders, Partners, and Fellow PCAs

Oregon Health Authority

OCHIN

CareOregon

CAMBIA health foundation

HRSA Health Center Program

Oregon Coalition Against Domestic & Sexual Violence

Washington Association of Community & Migrant Health Centers

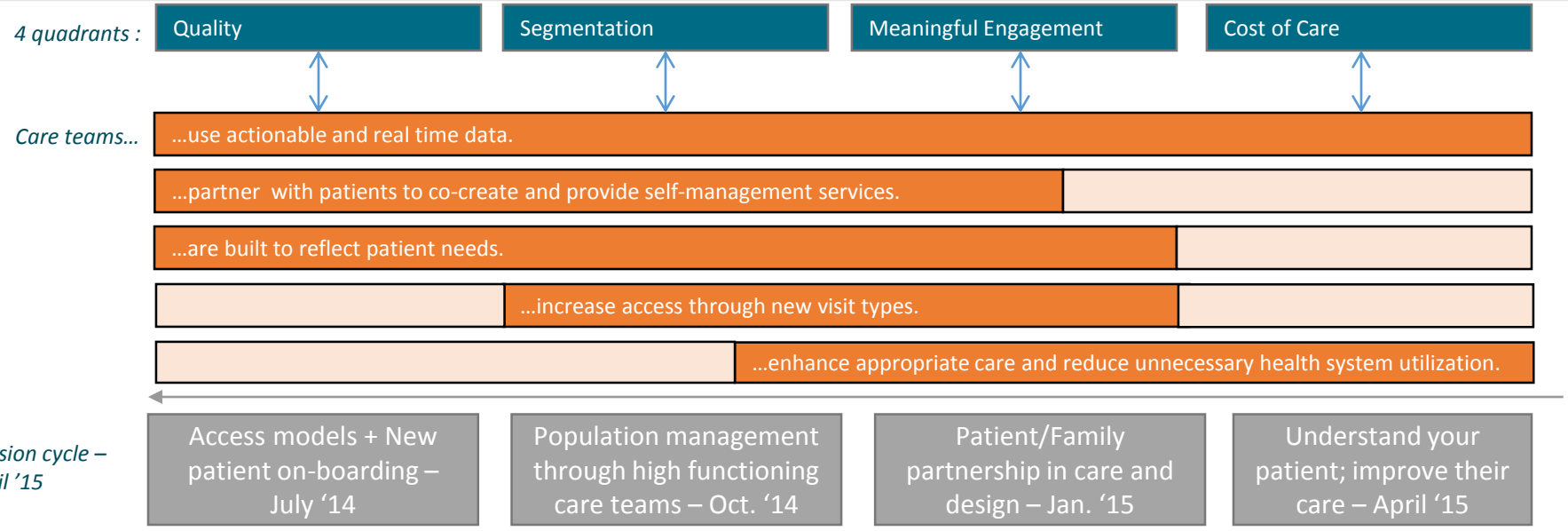
Colorado Community Health Network
Access for All Colorado

WPHCA Wisconsin Primary Health Care Association

Learning Session Welcome


Teams
Build care teams that are a reflection of patient needs
Appropriate Care
Enhance appropriate care and work to reduce unnecessary emergency department utilization and ambulatory care sensitive admissions
Partner
Partner with patients to co-create and provide self-management services
Access
Centered around patient's schedule, mode of preference
Data
Use actionable and real time data
5
FIVE
STRATEGIES

Advanced Care Model: Foundational TA



Learning Session Deep Dives

Identify a subpopulation of focus…

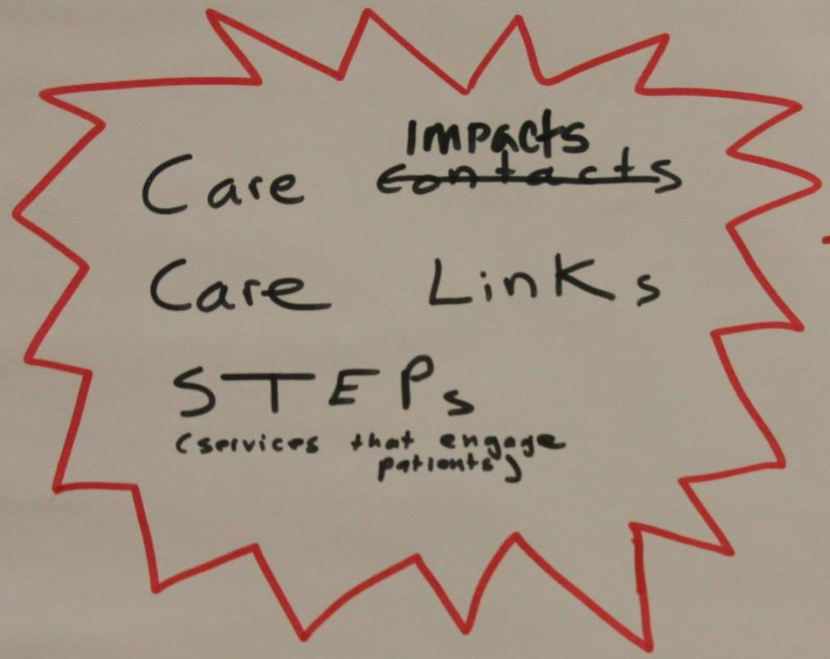
Test out…	…a new visit type.	…a new care team role.	…a new partner.	…a social care response.
Learning Session cycle – Oct '15 – Nov '16	Patient partnership and new visit types	Expanded teams and new roles	Community partnerships and solutions	SDoH interventions
Date:	October 16th, 2015	March 7-8th, 2016	July 22nd, 2016	November 3-4th, 2016

…Partner with them in meaningful ways.

Member Contacts =

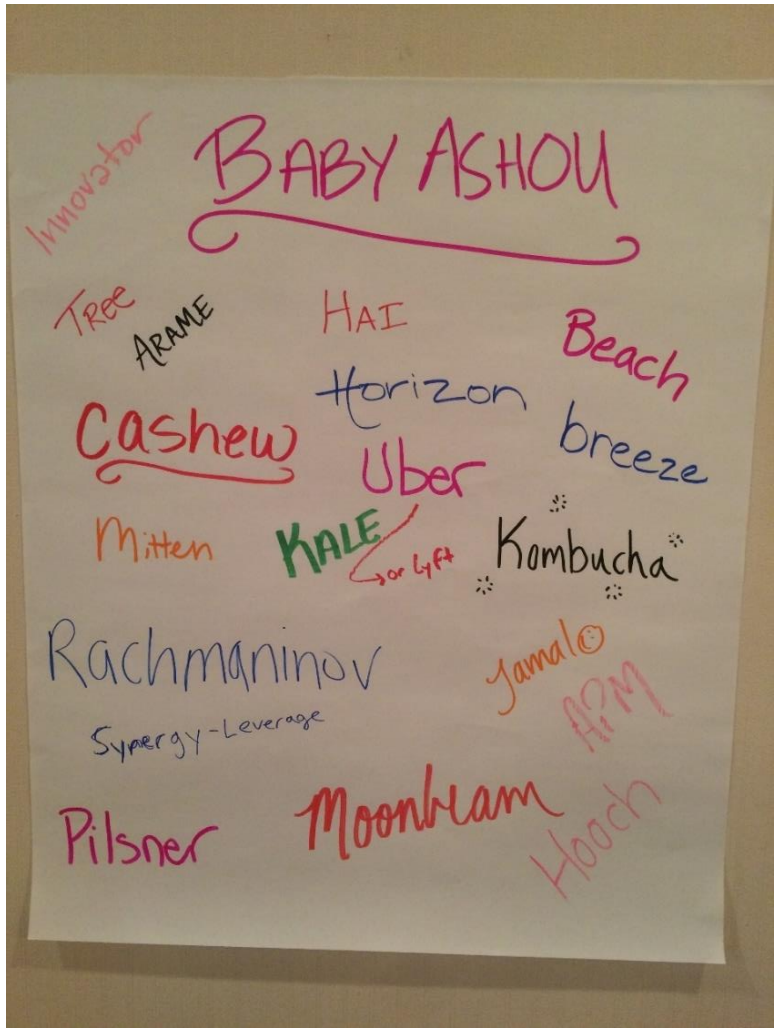
1. Pt Visits - Clinical
2. All Other - PCC, Front Desk, CHW, etc.

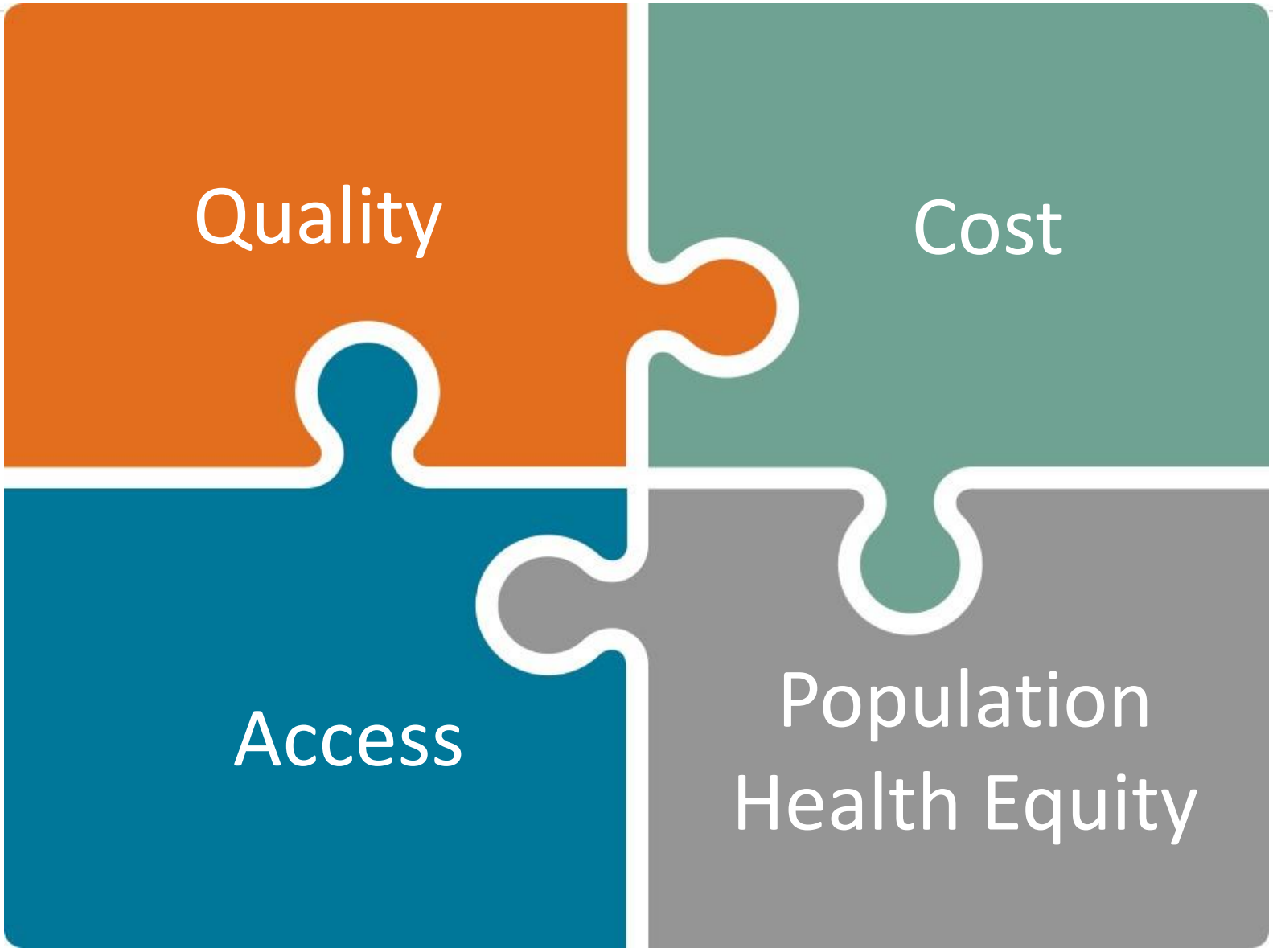
Touch Points

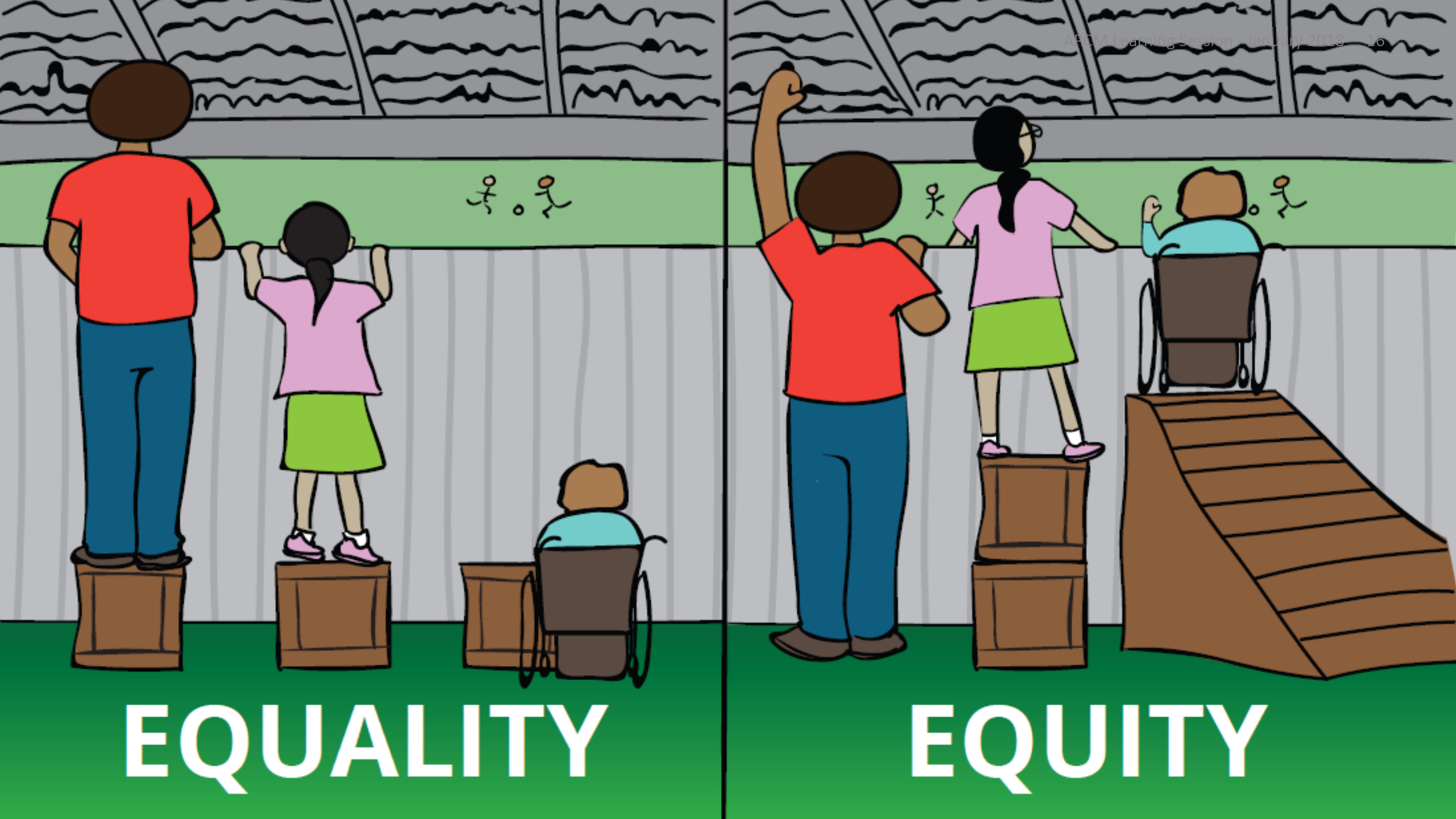


TOP 3

Our criteria:
- short + easy to say
- captures pt interaction + care coord.


Innovator
BABY ASHOU
TREE
ARAME
HAI
Beach
Horizon
Cashew
Uber
breeze
Mitten
KALE
or Lyft
Kombucha
Rachmaninov
Jamalo
Synergy-Leverage
Pilsner
Moonbeam
Hooch


Quality
Cost
Access
Population Health Equity


EQUALITY
EQUITY

Anchoring the Day

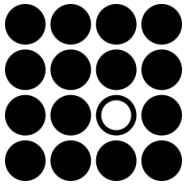

QUARTERS ONLY
25¢
TO OPERATE

Elements of Value

High level care

Deliver care to patients in different formats

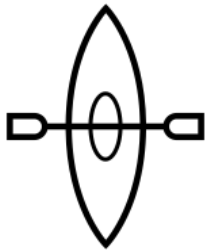
Re-distribute power so that patients become equal partners in co-creating their care



Synthesize and utilize population data to uncover gaps in community health

Elements of Value

High level care



Test out appropriate, upstream interventions for groups segmented using bio-psychosocial data

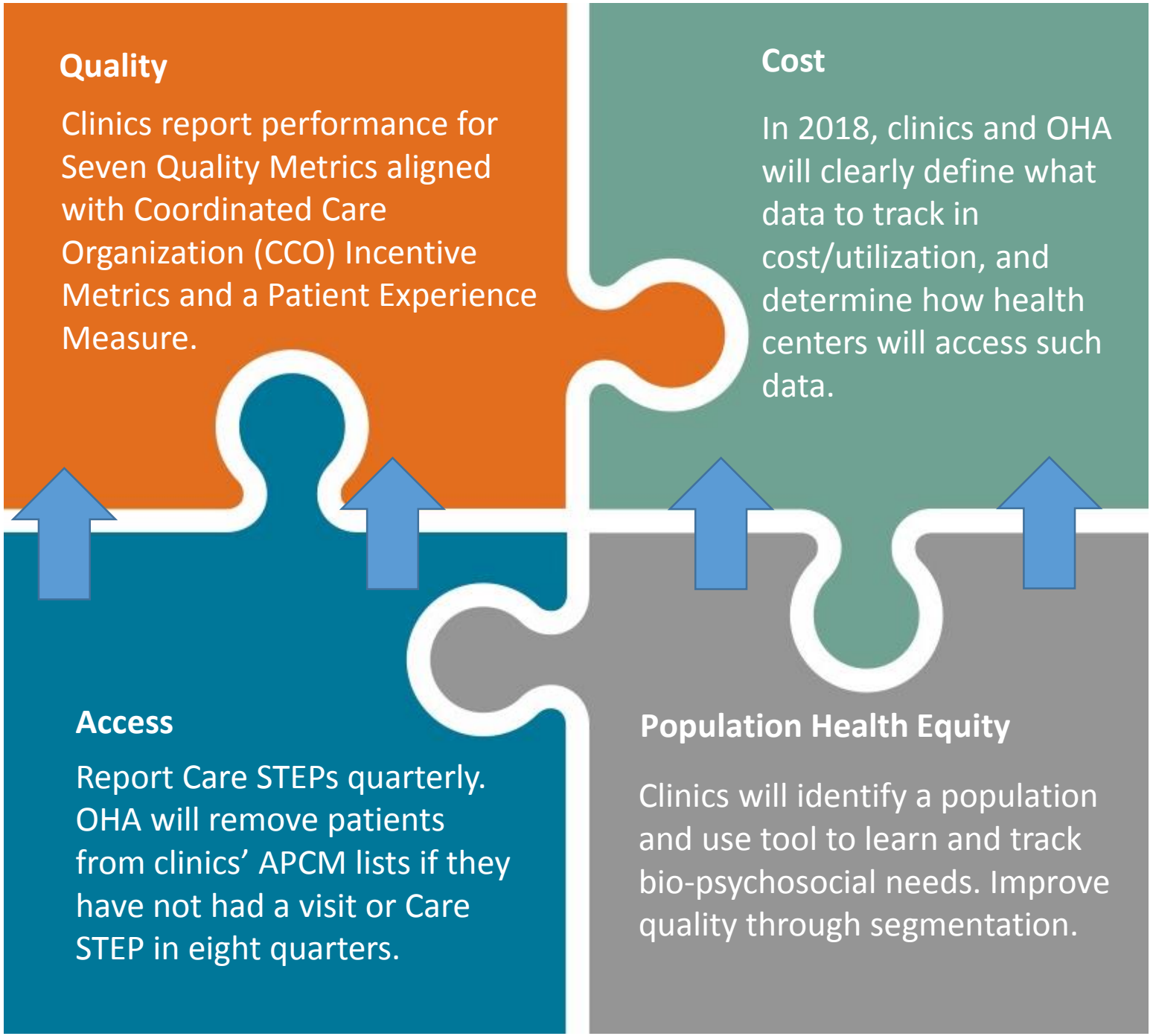
Continue to make strategic care connections involving community partners

Document, document, and document so you know who you are serving!


Shapes
2008
September
Calendar
Sunday
Monday
Tuesday

QUADRUPLE AIM

OREGON APCM METRICS AND ACCOUNTABILITY PLAN



**One metric to be added in 2019 (SBIRT).*

How may we use…

Data…

Design…

Skills…

…that informs current and future modes of care and services?

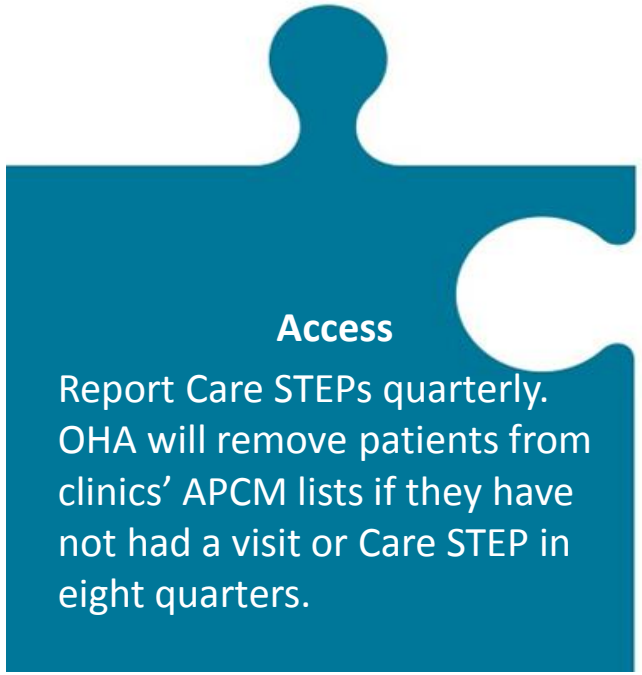
…that weaves in the patient voice?

…that make the vision tangible for front line staff?

…that uncovers population health disparities at the clinic level?

…that incorporates community partnerships?

…that encourages empathic inquiry and partnering between patients and staff?



APCM Transformation Goals

	Foundational	Intermediate	Advanced
Population Health Equity Goals:	Segment patient populations to a target set of patients and conduct a SDH screening to learn more about their bio-psychosocial needs.	Pull and routinely analyze data related to SDH issues for target populations.	Incorporate SDH data into panel management activities and use it to inform care-plan decision making.

	Foundational	Intermediate	Advanced
Access Goals:	Use the Care STEPs categories to develop one new mode of access/service delivery.	Evaluate patient engagement or satisfaction with new modes of access/service delivery.	Use Care STEPs categories to create one new patient-driven mode of access/service delivery for target populations identified through the PHE quadrant.