OHSU-Richmond

Characteristics of our patient population:
- Generally, inner city residents who are low income, uninsured, and underinsured. Typically unemployed or the "working poor." Thirty percent have incomes below 100% of the federal poverty level; 42% have incomes below 200% of the federal poverty level.
- Many immigrants
- High level of mental health and substance abuse in population
- Cardiovascular, diabetes, depression, infant mortality rate – all high incidences in our population.
- Fifteen percent of our users speak languages other than English: Vietnamese, Chinese, Russian and Spanish.

Demographic characteristics of the user population:
- 8,800 active patients
- 60% female / 40% male
- 125 prenatal users per year
- 100 deliveries per year
- 22% of patients are children
- 8% of patients are age 65 or older

DESCRIPTION OF SERVICES PROVIDED

Physicians, family nurse practitioners and physician's assistants provide a comprehensive range of primary and preventive services to patients:
- General primary medical care
- Women's health care
- A full spectrum of family-centered maternity care
- Pediatrics
- Full spectrum of preventive care for men, women, and children
- Referral relationships with OHSU health system and community specialists
- Geriatric care
- Minor procedures, hearing and vision screening, and oral health
- Basic lab and x-ray facilities are on site
- Mental health and substance abuse screening, treatment, and counseling is provided partly on site by our own medical providers, licensed clinical social worker, and part-time psychologist
- In-house 340B pharmacy which provides low-cost medications to all Richmond patients

Our four clinical teams each include:
- Clinicians – MDs, mid levels, residents
- Registered Nurse
- Medical Assistants (3)
- Team assistants
- Behavioral Health staff

Our behavioral health teams include:
- 1 FTE of an LCSW
- .5 FTE of an MSW
- .3 FTE of a Psy D
- Doctoral students in behavioral health and Psy D

Behavioral Health Work volumes:
LCSW & MSW:
- Appointments = 44 per month
- Warm hand offs = 280 per month
- Phone calls = 460 per month

Psy D Students:
- Appointments = 136 visits per month
- Warm hand offs = 16 per month

PARTICIPATION

What motivated your practice site to participate in this initiative?

As a teaching practice, preparing family medicine residents for future practice, and giving undergraduate medical students exposure to both primary care and care for underserved populations, we realized that we were appearing unsustainable and dissatisfied in our work. How could we honestly recruit and train future safety-net physicians when we ourselves felt compromised by inadequate resources, quality, and patient and provider satisfaction?

In 2006, a visit to South Central Foundation in Anchorage Alaska, sponsored by CareOregon (our major Medicaid managed care organization partner) gave us a vision of a Patient-Centered Medical Home and spurred a local learning collaborative to put the elements of the PCMH as we understood them into action. With some pre-existing interest and experience with behavioral health as part of Family Medicine's biopsychosocial and holistic model, we elected to address behavioral health integration as our signature initiative within the learning collaborative. We chose to invest nearly all of our initial investment in practice transformation into staffing accessible, real time behavioral health consultation, and expanding psychological assistance to our patients.

We knew that many chronic illnesses, and our patients' response to the stress of acute illness, are heavily impacted by health behaviors and mental health status. We knew that many of our patients struggled with substance abuse and depression. We also believed that efficiency of our office practice and patient satisfaction are affected by behavioral and mental health.

We anticipated this initiative would:
- Make our practice a more attractive site for learners
- Increase provider productivity and satisfaction
- Increase volume of behavioral health services provided "in-house" to our patients

CHANGES

What was the specific problem or issue being addressed?
Lack of access to behavioral health and mental health services for our clinic patients
What did you hope to achieve by making the change?
- More comprehensive and holistic care for patients
- Freeing up the PCPs to provide medical care while behavioral health issues were addressed by behavioral health staff
- Improved patient and provider satisfaction

What was the plan for making the change?
- Have behavioral health consultant available to see patients during visits with PCPs
- Have behavioral health counselors available to patients for short-term cognitive behavioral therapy to maximize change
- Integrate behavioral health staff into the Medical Home Team for wraparound services

What did you learn from the process of making the change?
- Demand for behavioral health services quickly exceeds supply
- Creativity and strong teamwork are essential for success
- Have every member of the team (not just providers) empowered to refer patients to behavioral health

What would you recommend to other sites trying to make a similar change?
- When hiring behavioral health staff, be sure potential hires are aware that behavioral health services are different from mental health services and require a hearty mix of courage and caution!
- Be sure your behavioral health staff has the will to work quickly, intensely, and for the short term.

PATIENT IMPACT

"Integrated behavioral health has provided a way for patients to get help with mental health issues that have felt threatening or overwhelming to them, while avoiding the stigma that has been historically attached to getting mental health treatment.

An example: A Vietnam veteran whose PTSD had caused a long slow deterioration of his living situation, and who had a long-term, positive connection with his PCP, was able to agree to meet with a behavioral health social worker to discuss options. He refused to access conventional mental health care because he did not think he had a mental health problem. Through the combined effort of the behavioral health provider and PCP in reframing the issues, the patient agreed to try out a local drop-in center that had capacity to provide informal mental health support while also working toward stable housing. The behavioral health provider, with authorization from the patient, paved the way for the patient to be brought into the program through the stable housing process, thus preserving his sense of dignity and control. He subsequently got connected through this center with informal mental health supports that have enabled him to maintain stable housing."

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"Integrated behavioral health makes services available to patients that they may otherwise be unable to access.

An example: A patient in a domestic violence situation had stayed for many years because her highly controlling male partner would not allow her to go anywhere except to see her PCP without him. (Often he even went to these appointments as well.) The PCP had a well-established, supportive relationship with the patient, and brought behavioral health staff in to provide information and support. Because the patient has numerous medical visits, both for herself, through a pregnancy, and for her several children, there were frequent opportunities for the patient to get counseling and support from both the PCP and behavioral health."

PROVIDER OR STAFF IMPACT

"Prior to PCMH transformation, I struggled to answer our providers and trainees when they questioned the sustainability of trying to meet ever-increasing patient, productivity, and administrative demands. It also seemed that there was no margin, in time or money, to invest in the work of improving our practice. This was especially true regarding our patients' mental health, substance abuse, and health behaviors.

Now I can clearly identify basic mechanisms, like just-in-time behavioral health consultation with warm handoff, or in-house psychological diagnostic assessment or brief cognitive-behavioral therapy, for dealing with difficult psychosocial issues. We also have basic mechanisms (team meetings, Lean workgroups, quality data dashboards) and additional staff roles (team assistants, quality managers) to allow practice improvement to occur on a routine basis. Change remains slow, and difficult, but far from impossible." —Medical Director

"Prior to initiating PCMH transformation, we averaged 50% of our graduates practicing in safety net sites upon graduation; we are now consistently at 75%. Prior to PCMH transformation, only one provider felt resourced adequately to provide office-based treatment for opioid dependence; now four of us provide this service." —Provider

Safety Net Medical Home Initiative

QUALIS HEALTH
THE COMMONWEALTH FUND
MacColl Institute at Group Health Cooperative