

Access for What?

Transforming Primary Care in Community and School-Based Health Centers

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Cabin Creek Health Systems



Physicians: 7 FTE

Psychiatrist: .1 FTE

NP / PA: 9 FTE

Pharmacists: 2 FTE

Behav. Health: 5 FTE

School-Based Centers: 3



Cabin Creek Health Center, Dawes, WV



Riverside High School (School-Based Health Center) Belle, WV

Riverside High School-Based Health Center



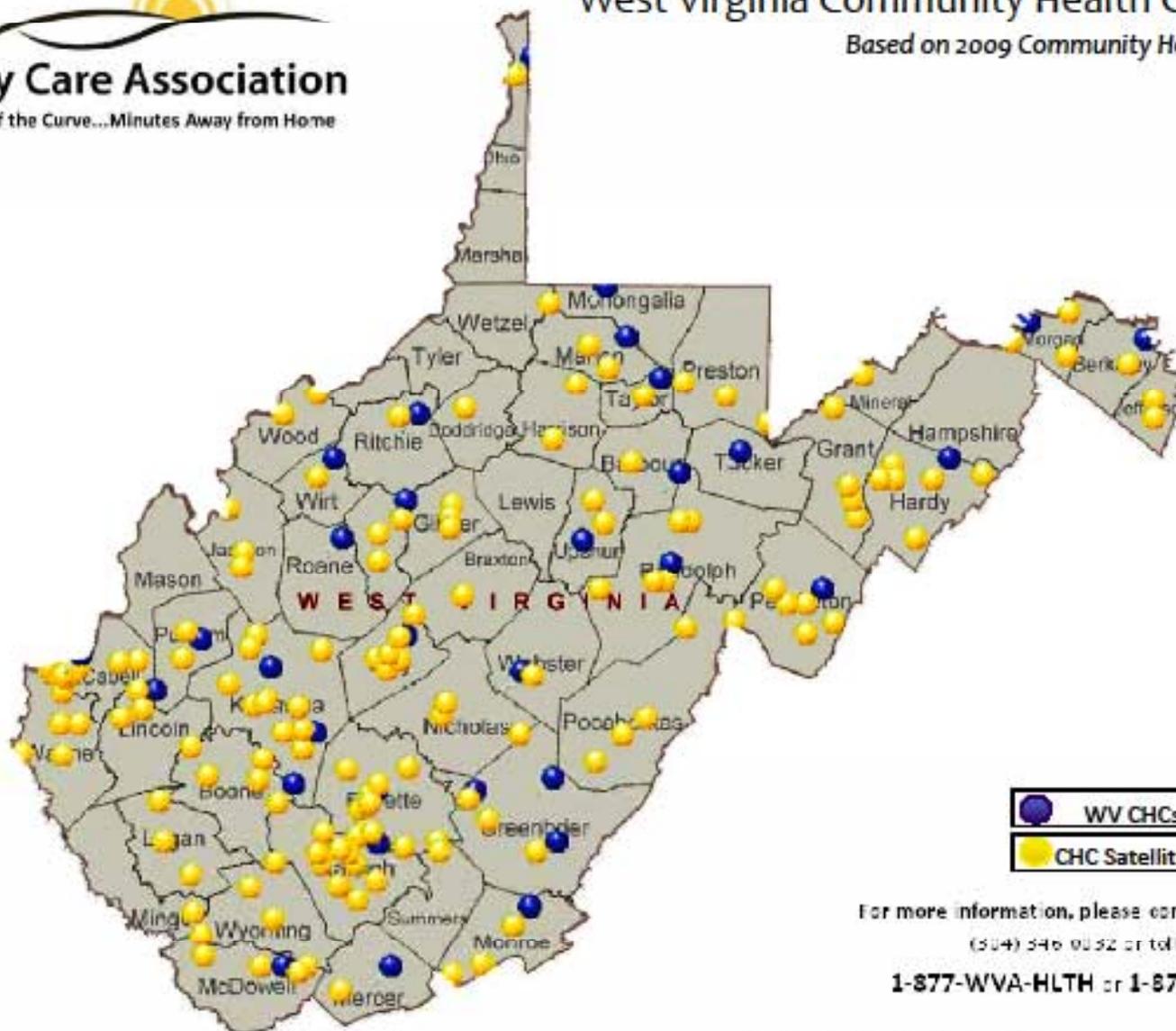
WELLNESS  THE WAGON
GET ON IT



We are part of a bigger system of
community-owned health centers
in West Virginia.

West Virginia Community Health Center Sites

Based on 2009 Community Health Center Data



For more information, please contact the WVPCA
(304) 546-9052 or toll free:

1-877-WVA-HLTH or 1-877-982-4584



CHCs provide care to many of West Virginia's most vulnerable residents

28 CHCs / 160 clinic sites / 375,000 patients

	% of CHC Patients	CHC Pts as % of WV Pop.	% of WV Population
Under 100% Poverty	55%	60%	19%
Under 200% Poverty	91%	47%	40%
Uninsured	26%	36%	15%
Medicaid	23%	32%	15%
Medicare	14%	17%	17%

So, let's appreciate the big gains in primary care access

And

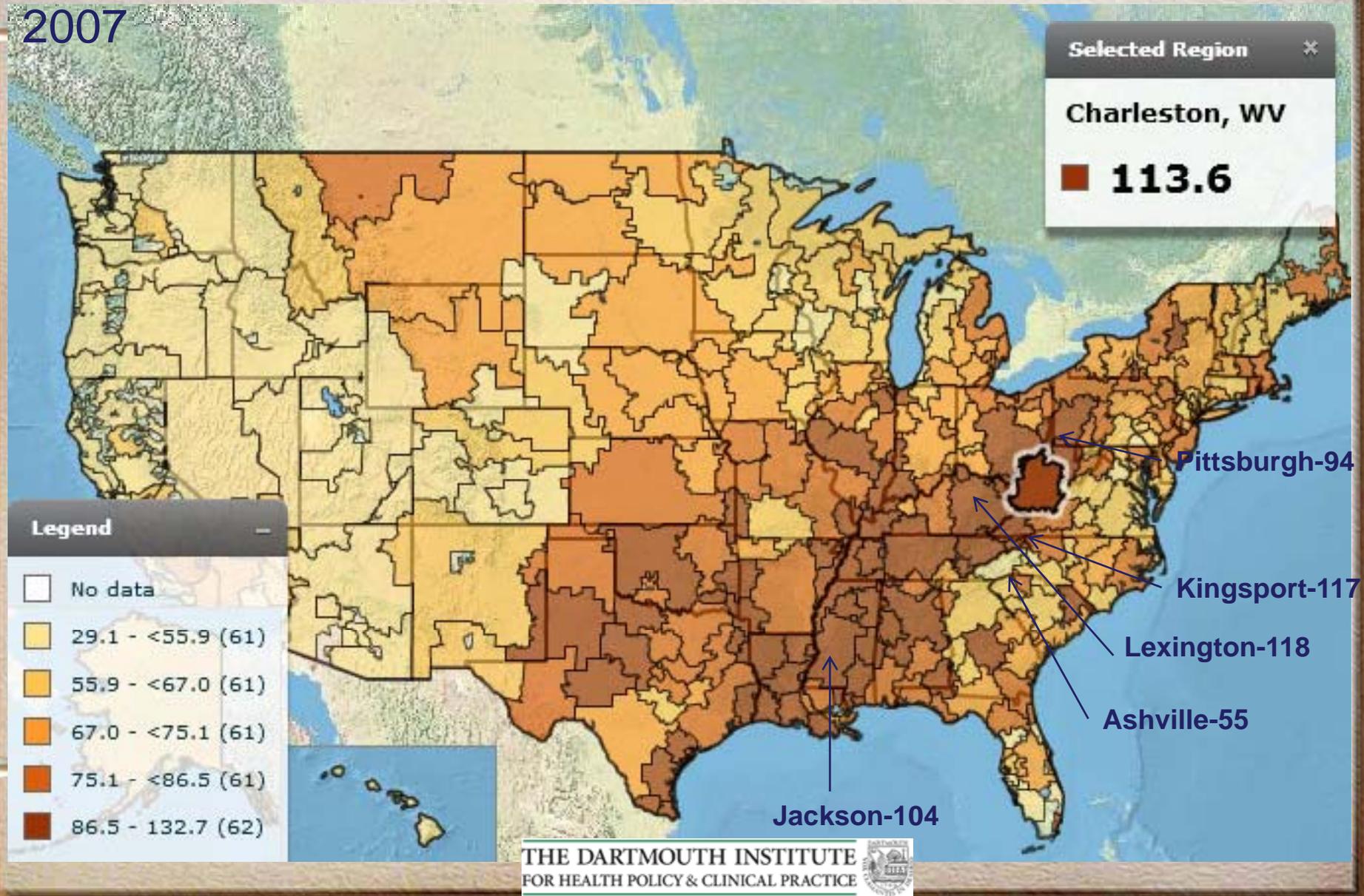
Let's ask: Access for What?
How do we use this infrastructure to address the big health problems facing our patients and our region (chronic disease and behavioral risks)?

There are many indicators that we have big problems with health status in central Appalachia:

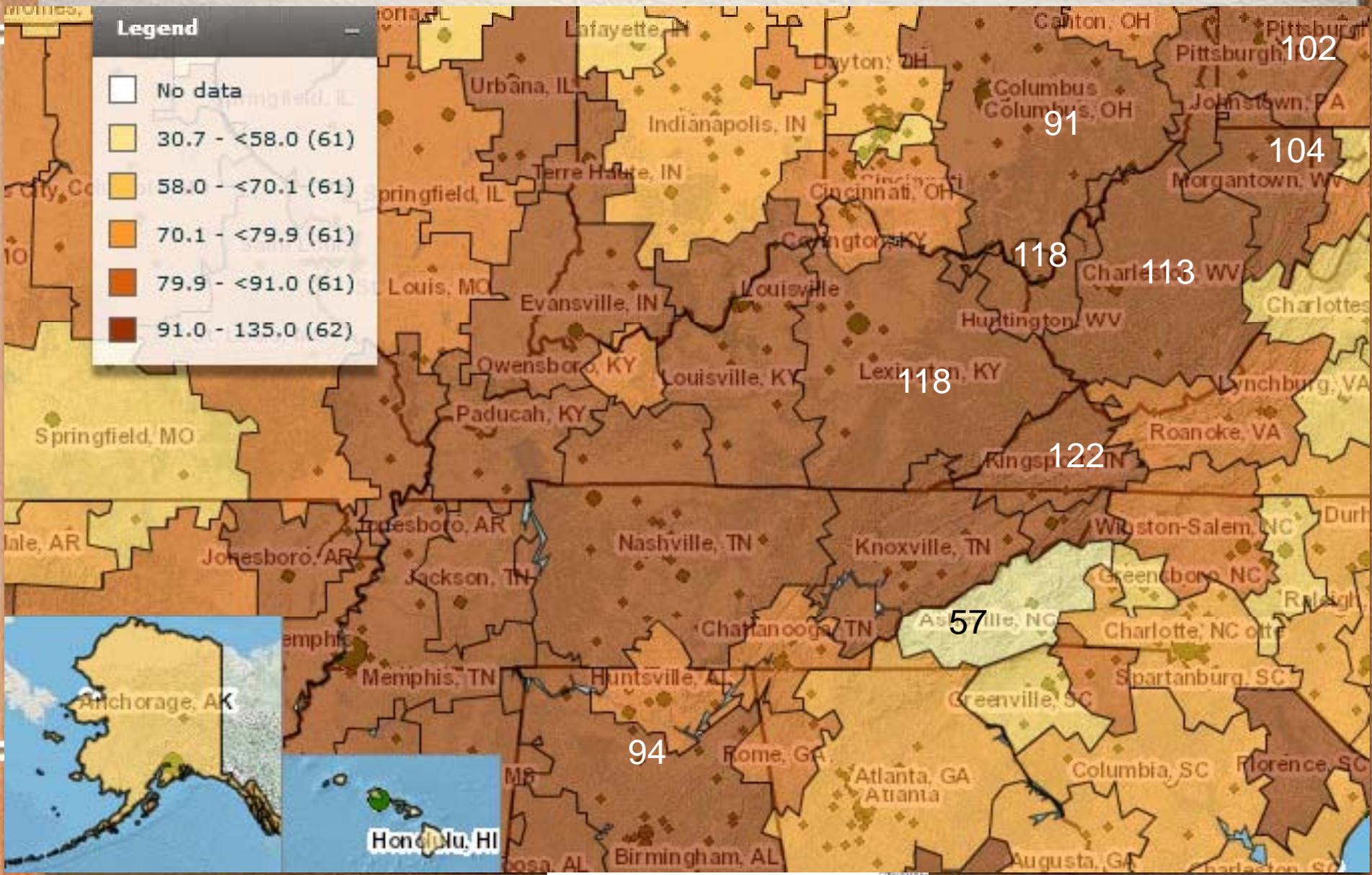
- High morbidity and mortality from chronic conditions.
- High rates of disability; and
- High behavioral risk factors.

And this map reveals another one: High hospital rates for ACSCs. *Points to high prevalence of chronic conditions, high cost and deficiency in quality.*

Discharges for ACSC Per 1,000 Medicare Enrollees – Year 2007

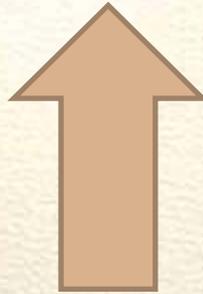


Discharges for Ambulatory Care-Sensitive Conditions per 1,000 Medicare Enrollees-Year 2007



The *Dartmouth Institute for Health Policy and Clinical Practice* tells us that, for Medicare Enrollees, there is a **BIG VARIATION** across the country in **COST** and **QUALITY** and the relationship is **INVERSE**.

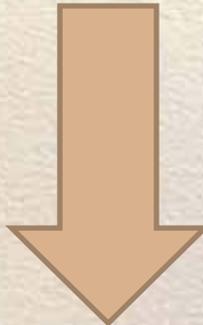
If Cost



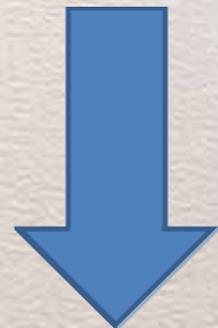
If Quality



Then Quality



Then Cost



Results of Health Risk Screening – One High School

56%	Do not eat 5 or more fruits and vegetables 5 days per week
73%	More than 2 hours per day of screen time.
32%	Have not seen a dentist in the last 12 months.
38%	Smoke cigarettes, cigars, use snuff, or chew.
10%	Use alcohol or drugs to relax, feel better about themselves, or fit in.
15%	Have thought about killing themselves, tried to kill themselves or have purposely cut themselves, burned, or otherwise hurt.
20%	Do violent things when they are angry.
56%	Are sexually active. (31% engage in unprotected sex)
7%	Have been physically, sexually, or emotionally abused.
65%	Have problems with concentration/focus in class.

Primary Care for At-risk Adolescents and Adults with Chronic Diseases presents a Technical and Adaptive Challenge for Patients and Health Centers

Improvement requires that at-risk patients make significant changes AND

That the medical centers make big changes

We believe that there are at least four big changes needed.

4 Structural Requirements to care for at-risk adolescents and adults

- 1. Use PORT3ALs to guide systems work.**
- 2. Integrate Behavioral Health and Primary Care.**
- 3. Hold regular interdisciplinary staff learning and care planning sessions.**
- 4. Do Health Coaching / Care Coordination**

PORT³AL as Metaphor and Acronym and
Reminder of who we work for.



PORT³ALs Guide the way to improved
Systems of Care for groups of similarly at-
risk patients in a primary care practice.

PORT³AL: A useful acronym to guide systems of care for at-risk populations

Population (*Who, specifically, are we working with?*)

Objectives (*What's our aim?*)

Relationships (*with Team, Patients & Resources*)

T¹asks (*What are the steps in the process?*)

T²raining (*What must we learn?*)

T³ools (*Registries, assessments, etc?*)

Administrative Support (*Meetings, etc*)

Logic (*Why will it work?*)

Integrating PC and BH

A Radical Model

1. **Radically Accessible:** Eliminate financial, waiting time, administrative and stigma barriers.
2. **Radically Collaborative: BHCs work side-by-side with PCPs** in the PCPs space, seeing patients in exam rooms - at the PCP's request - and seeing patients on the same day as the PCP.
3. **Radically Comprehensive: BHCs address everything:** chronic problems, psychiatric diagnoses, risk screening and health behavior change
4. **Radically Brief** – visits usually 20 minutes or less. “Who says you can't have an impact in 15 minutes.” (Kirk Strosahl, PhD)

Staff Meetings

A Radical Model

- Weekly Extended Team Huddles -- planning care for complex patients (include PCPs, MAs, PSRs, BHCs, CCs).
- Monthly Learning Workshop for Behavioral Health Consultants and Care Coordinators.
- Monthly - Morning Not-so-Grand Rounds (all clinical staff)
- Multi-site Workgroups including a Practice Systems Workgroup, Diabetes, Well-child and School Health Workgroups.

Health Coaches- Medical Assistants et al

(Connecting with Patients between visits)

- Frail Elder Care - Cabin Creek, WV
- Special Care Center - Atlantic City (Casino Workers Health Plan)
- Unite Health Plan – NYC (Garment Workers Health Plan)
- Behavioral Health Educators – WV-SBHCs (Sisters of St. Joseph Foundation)

Change work is hard.

But it is what is required of primary care practices to meet the Triple Aims of health improvement:

1. Improve Quality
2. Reduce Cost
3. Improve the Experience of Care for Patients and Health Workers.

THE END

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