Welcome to the
APCM LEARNING SESSION
January 25\textsuperscript{th}, 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
Learn who’s in the room!
<table>
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<tr>
<td>Mosaic Medical</td>
<td>Benton County</td>
<td>Clackamas County</td>
<td>Neighborhood</td>
<td>La Clinica</td>
<td>Lane County</td>
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<td>OHSU-Richmond</td>
<td>Multnomah County</td>
<td>Rinehart</td>
<td>NWHS</td>
<td>Wallace</td>
<td>Valley Family</td>
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<td>Virginia Garcia</td>
<td>OHSU-Scappoose</td>
<td>Rogue</td>
<td>Winding Waters</td>
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<td>Yakima Valley</td>
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Funders, Partners, and Fellow PCAs
Learning Session Welcome
FIVE STRATEGIES

Teams
Build care teams that are a reflection of patient needs

Data
Use actionable and real-time data

Appropriate Care
Enhance appropriate care and work to reduce unnecessary emergency department utilization and ambulatory care sensitive admissions

Access
Centered around patient’s schedule, mode of preference

Partner
Partner with patients to co-create and provide self-management services
Advanced Care Model: Foundational TA

4 quadrants:
- Quality
- Segmentation
- Meaningful Engagement
- Cost of Care

Care teams:
- Use actionable and real-time data.
- Partner with patients to co-create and provide self-management services.
- Are built to reflect patient needs.
- Increase access through new visit types.
- Enhance appropriate care and reduce unnecessary health system utilization.

Learning Session cycle – Jan ’14 - April ’15
- Access models + New patient on-boarding – July ‘14
- Population management through high functioning care teams – Oct. ’14
- Patient/Family partnership in care and design – Jan. ’15
- Understand your patient; improve their care – April ’15

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

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

Touch Points

Top 3

Our criteria:
- Short and easy to say
- Captures pt interaction and care coord.
BABY ASHOU

Tree
Rain
HAI
Horizon
Uber
breeze
Mitten
KALE
Kombucha
Rachmaninov
Synergy-Leverage
Pilsner
Moonshain
Hooch

amado
MPP

EQUALITY vs EQUITY
Anchoring the Day
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!
APCM Learning Session

Quality
Clinics report performance for Seven Quality Metrics aligned with Coordinated Care Organization (CCO) Incentive Metrics and a Patient Experience Measure.

Cost
In 2018, clinics and OHA will clearly define what data to track in cost/utilization, and determine how health centers will access such data.

Access
Report Care STEPs quarterly. OHA will remove patients from clinics’ APCM lists if they have not had a visit or Care STEP in eight quarters.

Population Health Equity
Clinics will identify a population and use tool to learn and track bio-psychosocial needs. Improve quality through segmentation.

*One metric to be added in 2019 (SBIRT).
**Data...**
- ...that informs current and future modes of care and services?

**Design...**
- ...that weaves in the patient voice?

**Skills...**
- ...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?

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**Population Health Equity**
Clinics will identify a population and use tool to learn and track biopsychosocial needs. Improve quality through segmentation.
## APCM Transformation Goals

### Population Health Equity Goals:

<table>
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<tr>
<th>Foundational</th>
<th>Intermediate</th>
<th>Advanced</th>
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<td>Segment patient populations to a target set of patients and conduct a SDH screening to learn more about their biopsychosocial needs.</td>
<td>Pull and routinely analyze data related to SDH issues for target populations.</td>
<td>Incorporate SDH data into panel management activities and use it to inform care-plan decision making.</td>
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### Access Goals:

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<td>Use the Care STEPs categories to develop one new mode of access/service delivery.</td>
<td>Evaluate patient engagement or satisfaction with new modes of access/service delivery.</td>
<td>Use Care STEPs categories to create one new patient-driven mode of access/service delivery for target populations identified through the PHE quadrant.</td>
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