Central City Concern

NAEH Workshop:

Health Home Models

Ed Blackburn, July 17, 2012

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Central City Concern

- **Mission:** Providing comprehensive solutions to ending homelessness and achieving self-sufficiency
- **Who we serve –** yearly, more than 13,000 individuals (single adults, older adults, teens, parents and children throughout the Portland, Oregon metro area.)
- **Our programs –** integrated primary and behavioral healthcare, addictions treatment, over 1,600 units of affordable housing, employment services

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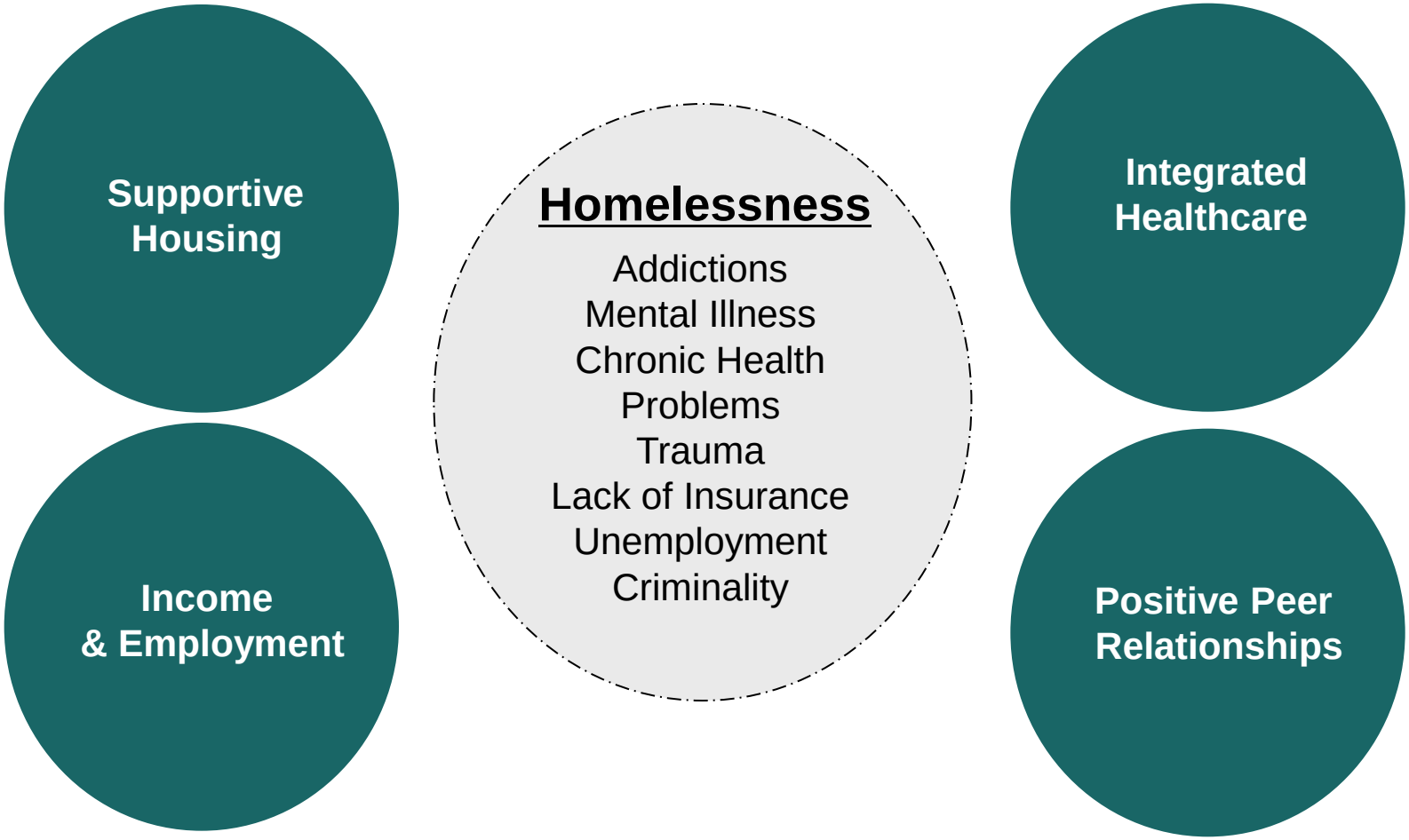
Comprehensive Solutions



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CCC Health Home Model

CCC Federally Qualified Health Center:

- Old Town Clinic
- Hooper Detoxification & Stabilization Center
- CCC Recovery Center
- Old Town Recovery Center (pictured)
- Recuperative Care Program

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Patient Centered Primary Care Home

CCC's Old Town Clinic was certified by the State of Oregon in 2011 as a Patient-Centered Primary Care Home based on meeting multiple measures under the following criteria:

- Access to care
- Accountability
- Comprehensive whole person care
- Continuity
- Coordination and integration
- Person and family-centered care

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Important Components of CCC Health Home Model

- **Barrier free access** – ability to get same day/next day appointments, reach care team directly by phone
- **Team-based care**: Four teams include primary care provider, behaviorists, pharmacist, wellness and chronic pain services to minimize risk of opiate use in patients with chronic pain
- **Highly integrated mental health and addictions treatment** into primary care setting
- **Resources to support wellness** and holistic approach to disease: occupational therapy, tobacco cessation, diabetes, depression

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CCC Health Home Model: Challenges

- **Barrier free access** vs. orderly operation of clinic – clinic schedule needs to be fluid to accommodate patients' needs, CCC continues to refine and improve scheduling and access systems

- **Pharmacy:** Patients with very high medication needs, many lack insurance; a difficult business model to maintain. Goal is to reduce multiple medications by emphasizing wellness.

- **High acuity client population**, multiple diagnoses

- **Access to housing:** some patients live in CCC housing but there is an unmet need for affordable supportive housing

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CCC Health Home Model: Partnerships and Funding

- **Federally Qualified Health Center**
- **University and health system partnerships:**
  - Oregon Health Science University Social Medicine Curriculum helps bring physicians and psychiatric nurse practitioners
  - Pacific University School of Occupational Therapy: supports chronic pain program
  - OHSU/Oregon State University College of Pharmacy – pharmacy services supported by faculty and residents
  - Recuperative Care Program funded by area health systems
  - CareOregon: innovative managed care partner to support Patient Centered Primary Care Home model and clinical innovation
  - Providence Health Systems: Funding extended hours/urgent care at Old Town Clinic and buildout for County dental clinic in CCC building

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Case Study #1

Before engagement at CCC:

- 30-year-old African American male
- Slept at his mother's house but wandered the streets all day
- Schizophrenia and asthma; IQ= 70
- Unable to use inhalers for asthma; did not take pysch meds
- Frequent user of EDs and ambulances

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Case Study #1

- Frequent user of EDs and ambulances

  2009: 40 ambulance transports to ED for asthmatic crises

- Hospitalizations:
  - 2009: 2 admits for schizophrenia
  - January 2010: Status asthmaticus

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Case Study # 1: CCC Investments

Old Town Recovery Center - ACT Team (Assertive Community Treatment)

10 Team members:

- Nurse
- Employment specialist
- Consumer
- Psychiatrist
- Case managers (MSW or QMHA)

Approximately 120 clients per team

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Case Study #1: CCC Investments

- Daily home visits to teach him to use his psychiatric and asthma medications.
- After stabilization, he gets primary care at CCC
- Receives nebulizer on site at Old Town Recovery Center 3 times/week. If he fails to appear, team goes out to his house
- CCC's BEST Team helps him get on disability

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Case Study #1: Current Status

- Client is on Oregon Health Plan Plus
- Continues to maintain stable housing
- Taking his psych meds every day
- Now able to use asthma inhaler
- Engaging with other clients and staff.
- **Zero visits to hospitals or emergency after October 2010**.

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Case Study #1: Cost Avoidance

	2009	CCC 2010	CCC 2011
Psych hospital admits*	$17,800		
Asthma hospital admit		$6,000	
E.D. admits for asthma**	$60,000	$28,500	
Transports to E.D.***	$20,000	$9,500	
Primary care		$1,610	$805
ACT team at CCC		$22,185	$11,092
Total	**$97,800**	**$67,795**	**$11,897**

* Per APAC data base Oregon

** Based on $1500/visit

***Based on $500/transport per article in EMS1

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Case Study #2

Before engagement at CCC:

- 53-year-old male
- Paraplegic
- Poly substance abuser
- Behavioral problems
- Chronic decubitus ulcers
- Chronic hepatitis C
- Gangrenous foot with multiple amputations
- Called 911 nine times in 18 months
- More than 50 problems on problem list

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Case Study #2: CCC Investments

- 2008-2009 Recuperative Care Program: 2 admissions for combined 86 days
- Supportive housing
- Wound care at RCP and Old Town Clinic

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Case Study # 2: Current Status

- Has permanent housing
- Positive and regular engagement with primary care provider
- Wound and decubitus care in clinic prevents hospitalizations and ED visits

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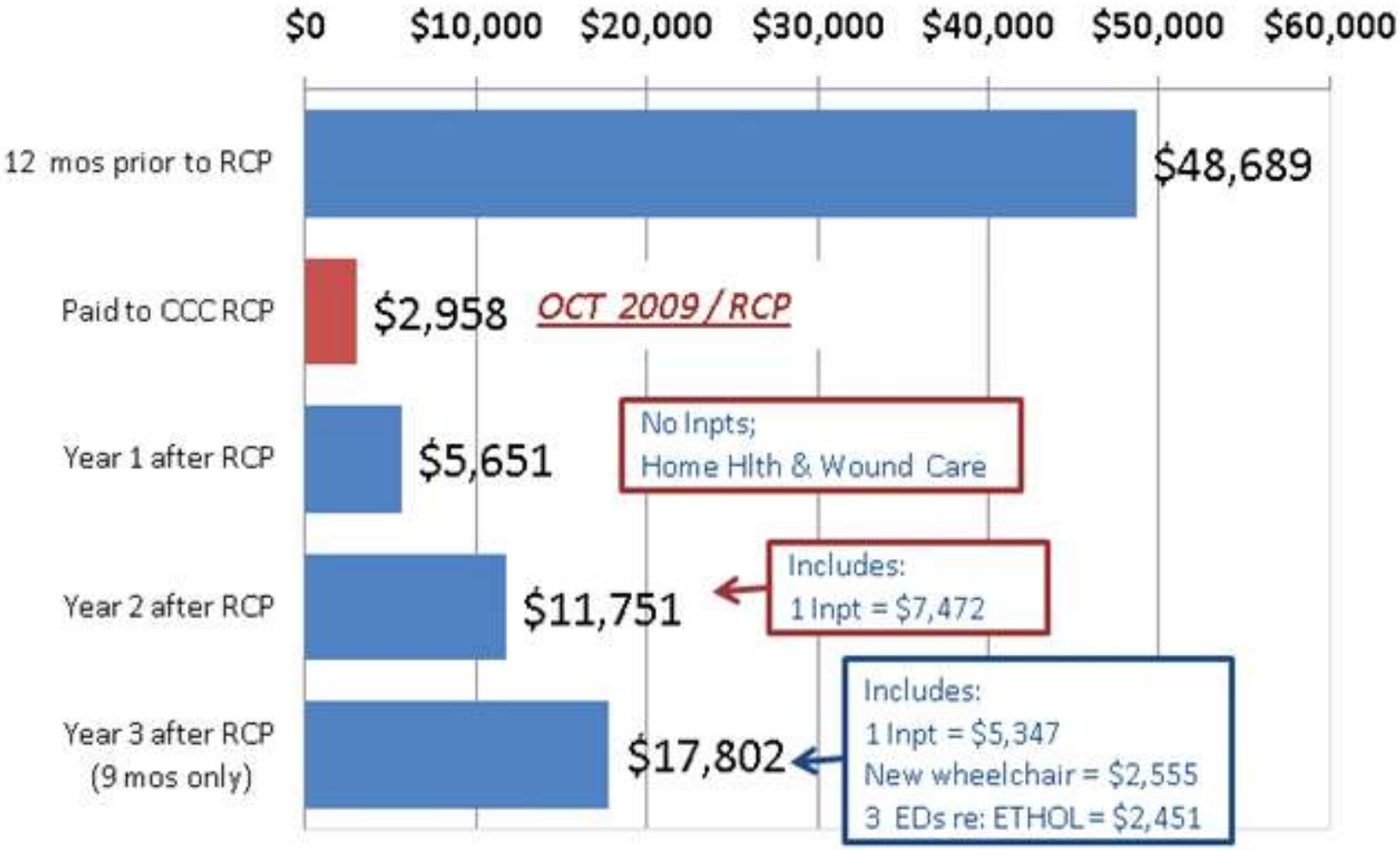
Case Study #2: Cost Avoidance



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