Using PCMH to Radically and Audaciously Care for Those Experiencing Homelessness

Share Our Selves Corporation, Costa Mesa California
Karen McGlinn, CEO
Mary Ann Huntsman, Director of Clinical Pharmacy
Integrated Care Agency

- **1970**: SOS founded as a social service agency for low income, migrant, homeless
- **1984**: Established Medical Clinic, Established Dental Clinic, Established Integrated Behavioral Health, Established Integrated Clinical Pharmacy Services, Began establishing other clinics in areas of need
- **2012**: FQHC with Health Care for the Homeless Provider Designation, Health Mobile Unit
- **2016**: SOS Center of Care for the Homeless
An Integrated Care Agency is a person centered, personalized partnership that takes into consideration the full range of body, mind, spirit, and community that are necessary to create a state of well-being for each person.
Integrated Services

Social Determinants of Health

- Environment
- Economic Stability
- Health and Health Care
- Social & Community Context

Community

- Across the lifespan
- Social Justice
- Personalized care strategy
- Well being, wellness

https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
Why do we do this

We are Mission driven:

- We are Servants who provide care and assistance to those in need and act as advocates for systemic change
- Personalized care for the Orange County community

We are driven to audaciously advocate for systemic change:

- because it is not easy, but it is right
- because it is sound and we must lead
Who, What, Why, When
Tell Your Story

This is our story
This is who we are

- Gold Standard
- Broad support from Private Sector
- Broad support from Federal Government
The patient-centered medical home is a way of organizing primary care using teamwork and technology to improve quality and patients’ experience of care, and to reduce costs.
2017 PCMH

- 6 Concepts

- Subdivisions within the Concepts

- Core (meet all core criteria)
- Elective (earn 25 credits in elective criteria)
- Guidance and Evidence
### Structure of PCMH 2017

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
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<tbody>
<tr>
<td>Team Based Care and Practice Organization</td>
<td>Communicate roles and responsibilities, and train staff to work to the top of their license</td>
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<tr>
<td>Knowing and Managing Your Patients</td>
<td>Deliver evidence-based care with culturally and linguistically appropriate services</td>
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<tr>
<td>Patient-Centered Access and Continuity</td>
<td>24/7 access to clinical advice and appropriate care</td>
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<tr>
<td>Care Management and Support</td>
<td>Tracks tests, referrals, and care transitions to achieve high quality and low cost care</td>
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<tr>
<td>Care Coordination and Care Transitions</td>
<td>Track tests and coordinates care</td>
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<tr>
<td>Performance Measurement and Quality Improvement</td>
<td>Culture of data-driven improvement on quality, efficiency and patient experience</td>
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Resources Provided by PCMH

- NCQA Representative
- PCMH Standards and Guidelines
- Annual Reporting
Our Journey

Economies of scale
Best Practices
All teach All learn
Roadmap for transformation

3 Clinics with new submission
1 Clinic resubmitting
Teams formed at each Clinic site
PCMH Working Structure

**People**
- **Subject Matter Expert**
  - Coach
  - Clears the way, provides resource

- **PCMH Coordinator**
  - Point Guard
  - Coordinates team
  - Keeps teams moving forward, leadership

- **PCMH Team**
  - Meets 1-2 times a week
  - CBOM, nurse manager, provider
  - Does the heavy lifting

**Process**
- **Readiness Assessment**
  - Pulls team together
  - Gap analysis

- **Task list**
  - Overcome inertia
  - Accountability
  - Status updates

**Organization**
- **Dropbox, access files**
- **3 eyes (place, view, PDF)**
- **Nomenclature**
Foundational Transformation

- EHR
- Population Management
- Care Coordination & Tracking
- Self Management Tool
- Data Analytics
- Empowerment
PCMH in the Homeless Population

**General Population**
- Triple aim
- Support teamwork
- Integration of technology
- Beyond organizational walls
- Coordinate services
- Total Patient Care
- Reduce barriers to care

**Homeless Population**
- Supportive network
- Behavioral Health
- Social Work
- Homeless Specialist
- Self management
- Care Plans, MTM, self efficacy
- Ease of access to care
- Effective use of resources

**Effective Navigation**
- Discover Gaps
- Needs assessment
- Patient survey in clinic
- Voice of the patient

**Healthy Behavior**
- Address Barriers
Lessons Learned

Leadership buy in, PCMH Coordinator, regular meetings

Start early, be systematic, next steps identified, empower

Use your resources, collaborate with others, network

Understand your data and CQI

Teams and Technology