The Assignment

Approximately 20,000 in this corridor with no access to Team Based Care
- 2 FHO practices across 5 sites

Client profile
- Chronic Disease / Pain
- Cyclical and generational SDOH – housing, income security, transportation, etc.
- Mental Health
- Substance Use
- Social Isolation
Our Goals

• Use both health equity and quality improvement approaches in the design and delivery of care
• Ensure that as many people as possible are connected to the right health care professional at the right time
• Improve integration and to work collaboratively with major stakeholders, including patients, FHO physicians, hospitals and others.
• Create more efficient and sensible processes that are easy to deploy
• Focus on preventative care by utilizing health data to proactively make connections between the patients and the health care professionals and services
What went well?

• 20 / 27 Physicians Referring
• Quality Approach
• Outreach = Spread
• Cohesiveness of the team
• ‘Streaming’ Assessments
• Pharmacist Pilot spread
Implementation Challenges

• 3 Weeks to design a million dollar plan
• Physician Involvement
  ➢ Intent vs reality
• Referral based system creates a barrier
  ➢ Case Finding
• Data collection and reporting
• Designing the Intake Process
• Managing the change – impact on entire organization
Resolutions to Challenges

• Commitment to the goals
• Relentless, frequent and prescribed communication
• Persistence - rapid tests of change
• Use the data – Pharmacist Pilot
• Streaming re: SDOH
• Outreach
• Monitoring integration
Advice Going Forward

- Hire facilitator with the right credentials
- Complete needs assessment before committing to FTEs and disciplines
- Eliminate the referral and use the data
- Agree on how to collect and report on data in the beginning
- Don’t minimize the change
- ‘It’s the long game’
Questions?