Partners in Integrated Care
Medical • Dental • Vision
Behavioral Health • Education

THE PIC PLACE

We are proud to provide exceptional patient-centered care for a low-income population while delivering high quality comprehensive care that is 14% less expensive than other practices in the region. We do this through a unique business model and a commitment to empowering patients.

Bringing humanity into healthcare is what we are about at PIC Place, a nonprofit health clinic that provides medical, dental, vision, behavioral health and physical therapy within a highly integrated delivery model.

Our internal measures of success are patients' expressions of being well-cared for, of feeling valued and respected, of being able to get the care they need. We are rewarded daily by patients' comments. Yet we also succeed in areas that matter to others: we have excellent clinical quality measures and a total cost of care that is 14% lower than other primary care practices in the region, according to data from Rocky Mountain Health Plans, the regional Medicaid carrier.

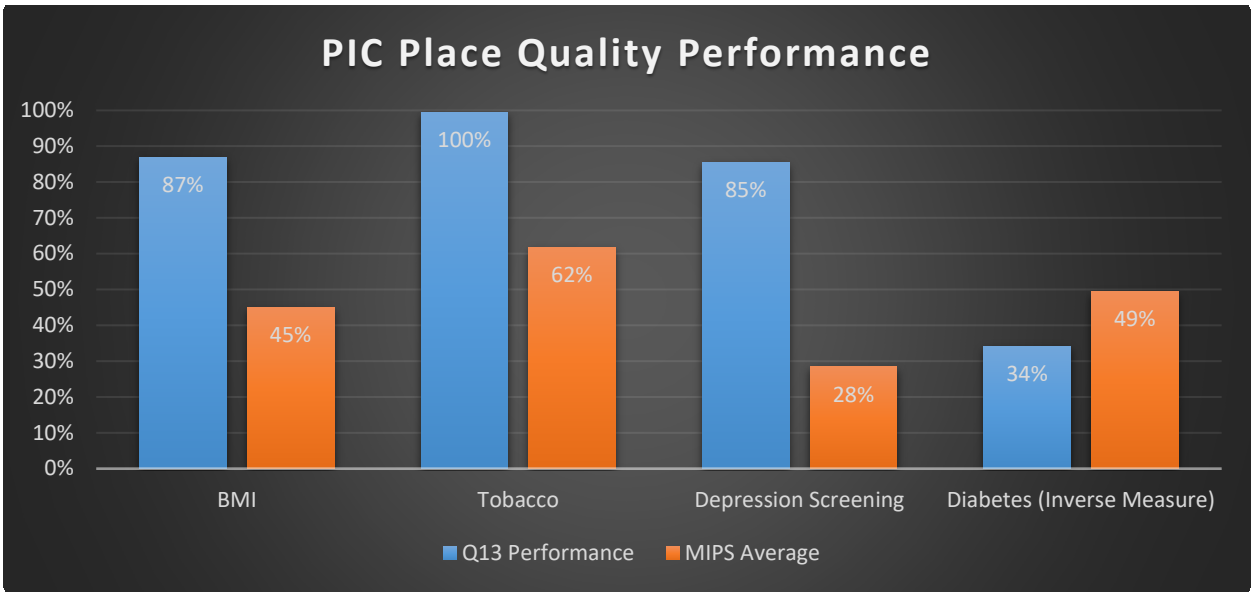
Our integrated model grew out of a nonprofit dental clinic in rural Western Colorado serving low-income patients who are at or below 250% of the poverty level. We knew that 70% of our patients did not have a primary care doctor and needed, and were not receiving, behavioral health care. To address the unmet needs of our dental patients, we reinvented ourselves based on a business model that would expand our dental services and meet the other health needs of this population.

Not coming from healthcare myself, our model was written entirely from the patient's perspective. I drew on my own experience, the experiences of family members and friends who needed health care and found the system confusing, expensive and often inaccessible.

I knew enough to know it needed to be different, radically different, but I didn't know enough to understand how innovative what we were proposing really was. This would be the first full integration that began from the dental side. We opened in June of 2017 with a three-year gradual growth model planned. That didn't happen. We reached our end of year two goal within 5 months. Our original dental patients loved it, they got what they told us they wanted, and in their enthusiasm, they told all their friends. Today we have over 5,000 patients in our integrated clinic that includes a rapidly growing primary care panel of 1,800 patients, growing at a rate slightly over 100 patients per month from December 2017 to December 2018. We accept all patients regardless of diagnoses or medications and we do not ever dismiss patients from our practice. They are always welcome.

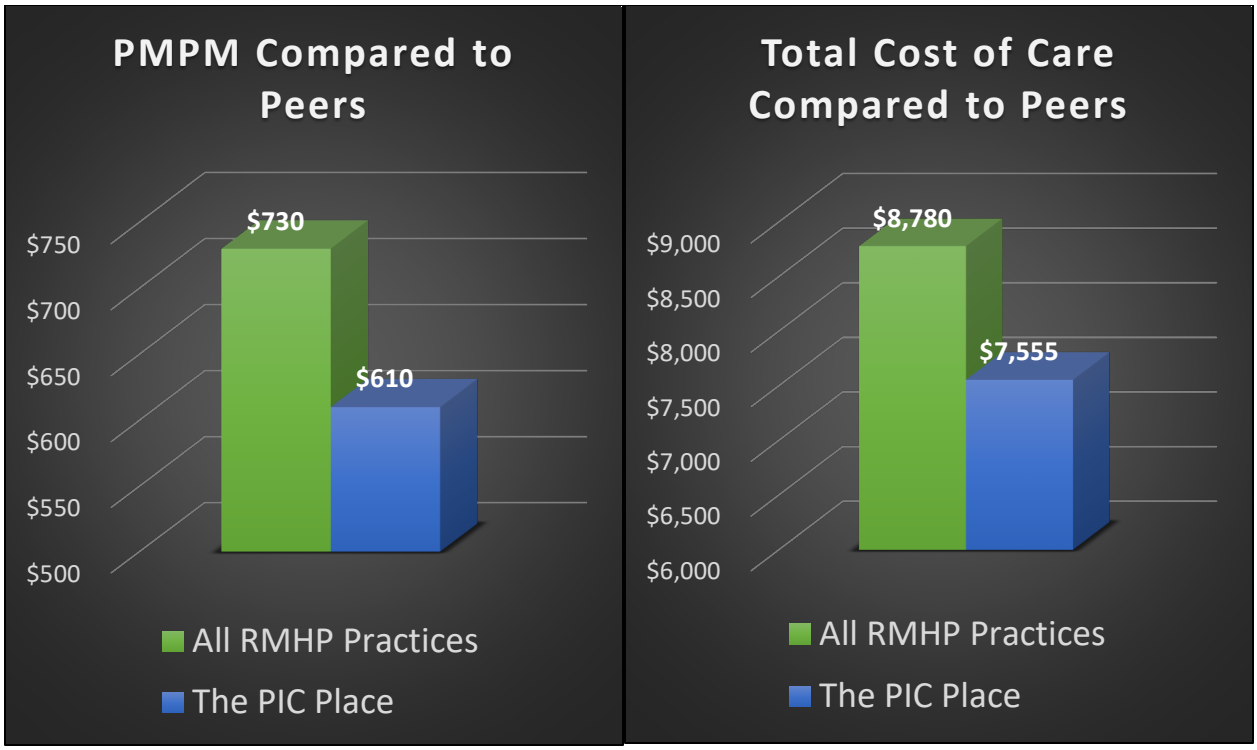
80% of our patients are on Medicaid and the others are on a sliding scale based on their income. We are proud to say that we turned a profit after only six months.

So, what do we do differently? For one thing, we don't chase outcomes or clinical quality measures. We chase patients. We pursue them, we engage them, we support them, and this approach has enabled us to achieve excellent clinical quality outcomes. Staff no longer sees boxes to click to satisfy measures. They see them as processes of discovery-opportunities to help our patients. This approach gets results: our depression, BMI and tobacco measures are all in the 90th percentiles.



We ask questions, lots of them. We begin from the place of believing that the patient has the answer. They are the expert. Their understanding of their own lives trumps any advanced degree, salary, or traditional healthcare hierarchy. We address patients' real needs. All our patients have some social determinant factor that affects their wellbeing. Homelessness, transportation, or food…the needs are overwhelming. We developed our own social determinant screener called Circle of Support. This is the launching pad for our case management

We respect and acknowledge each patient. Respecting and empowering patients is our "secret sauce" and it nets unbelievable gains. They show up to their appointments. They make lifestyle changes and they become healthier. It's the patients that allow us to financially thrive in the evolution of value-based care. Over a six-month period, we decreased our total cost of care by 16%, which was achieved through our complex care teams focus on high utilizers, and the corresponding reduction in ED visits that followed. Our per member per month total cost of care was 14% below our peers even though our patients are more complex and have considerably fewer resources than the patients of other primary care offices in the region.



We create a regular and ongoing feedback loop with our patients. We, like many practices, have established a Patient and Family Advisory Council. But for us, that was like the equivalent of inviting the family over for a formal sit-down Christmas dinner. It feels that way because we have “family dinners”, so to speak, with our patients daily. They are engaged with their health home and regularly share what they like, what they don't like and what would make it better; and trust me, they aren't shy.

To deliver our innovative care approach requires that we invest in a lot of professional development for our staff. We employ both traditional and professional development. For instance, we discuss a clip from the show New Amsterdam simply to see the power that comes from asking patients, "How can I help?" We insist on a team-based workplace. We study how basketball teams come together to execute plays. We huddle up every morning with the goal of excelling at the "assist"; setting patients up to take the winning shot. We coach one another on a regular basis. And "bench" those staff members who can't play together as a team.

We educate staff on how value-based care works. Our reality is that the majority of our primary care reimbursement comes through a managed Medicaid program that pays $33 per member per month. We explain this to staff in terms they understand: “Think of yourself as the parent of a teenager. Now consider you have just 30 minutes once a week to parent. Yet, you are still responsible for their decisions and outcomes. How do you spend that 30 minutes?” You are not going to be late or distracted, you skip the lecture, you would want to know what obstacles your teen is facing and develop a solution that will help. You begin the 30 minutes by saying "what matters to you today?” This is how we structure our encounters, with the same type of interested urgency.

To address the needs of our sub-population of “high utilizers”, we developed the Complex Needs Team, a cross disciplinary team of providers who work with the highest need patients. They have weekly, multi-disciplinary case conferences and regular, sometimes daily, communications with these patients

and their support system. We have a “shared care plan” that begins with the patient’s goals, in the patient’s words.

We created our own shared care plan. When looking at the templates and samples, we found them rather flat and uninspiring. Our care plan is the “Journey to Health”.

Here’s how it worked with a patient I will call Jeff. Jeff is a challenging patient who bounced around to various practices, often being dismissed and labeled as “drug seeking.” We started with the “end in mind”, which we call “Point B.” We asked Jeff, “What does your healthiest vision of yourself look like?” He was caught off-guard by the question. He said he had never thought about that, let alone been asked that question. It took some time to draw this out of him but then he started describing his vision: being able to golf twice a week, waking up feeling rested, and being happy, rather than fighting with his wife. Now we had a goal, one that we all understood and agreed upon.

Then, we looked at where he is today, Point A, which is his current health. Now we connect Point A to Point B by filling in the mile markers along the journey. These are the chronological goals:

He agreed to taper his use of narcotics, exercise, and find ways to get along better with his wife. Then came the true test because he was a heavy smoker. It was time to have that conversation. I asked what else we needed to talk about. He said this is the point where the doctors always lecture him about quitting smoking. The primary care doctor nodded, but instead of a lecture, he went back to the picture and asked Jeff, “Would quitting smoking move you closer to being the person you want to be? One who golfs regularly, wakes up rested, and gets along with his wife?” "Of course it would." So, we added it as a goal.

In the readiness to change assessment, he had just reached the contemplation stage. Success! And we got there together. By the way, he asked to take his care plan home to look at later!