My patient is your client.
My client is your patient.

Title: Building Effective Partnerships with Community Resources

Speakers:

- Janet Hamilton, Project Access NOW
- Dan Herman, 211info

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Today's Agenda

1. Introductions
2. Overview of Project Access NOW
3. Overview of 211info
4. Collaborations
5. Group Discussion
6. Bringing It All Together and Next Steps

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Project Access NOW

Improving the health and well being of our community by creating access to care and services for those most in need

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Who We Are

Project Access is a national model

- Coordinated and donated healthcare

The **NOW**

- Initially added to represent Northwest Oregon and Washington state
- Currently reflects the urgency of our work

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Our History

- Formed in 2007
- Established with support from all Portland metro area hospital systems
- Service area included Multnomah, Washington, Clackamas and Clark counties
- Infrastructure was built in partnership with: United Way of the Columbia-Willamette, Coalition of Community Health Clinics, other FQHC's and free clinics
- Began serving clients in 2008

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Our Vision

A healthy community with consistent access to care, services and resources needed for all to stay healthy.

- Project Access NOW can't reach this vision alone
- Achieving this vision is complex and slower than we would like
- Attaining our vision takes collaboration, alignment and investment across sectors

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What We Do

We turn community health visions into community wide solutions

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Our Programs

- Project Access NOW Classic
- Community Assistance Program—C3CAP
- Pharmacy Bridge
- Outreach, Enrollment and Access
- Premium Assistance
- Community Pathways
- Regional Social Determinants of Health Network (program under construction)

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Project Access NOW **Classic**

- Service area includes Multnomah, Clackamas, and Washington counties
- Uninsured individuals below 200% of federal poverty level
- Coordination of donated primary care, specialty care, labs, and diagnostic services
- Referrals from safety net clinics and other healthcare providers
- Interpretation support
- Access to medications
- 'Bridge' between coverage eligibility periods *(when applicable)*

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Community Assistance Program
C3CAP

- Includes all Providence and Kaiser hospitals in Oregon
- Supports a safe and secure discharge from hospital and emergency department
- Administering Flexible Services for Health Share of Oregon (not Care Oregon at this time)
- Wide range of services available

Example of services:

- Transportation—taxis, ambulance, bus tickets
- Housing—hotel vouchers, guest housing, rent assistance
- Medications—including copays
- Food Support—cafeteria vouchers, Meals on Wheels, grocery delivery
- Diabetic Supplies

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Outreach Enrollment & Assistance
Premium Assistance

- Assist individuals to enroll in a Qualified Health Plan (QHP) or the Oregon Health Plan
- Increase health insurance literacy
- Insurance navigation services
- Premium Assistance for QHP enrolled (eligibility requirement)
- Outreach and ‘enrollment’/voucher for “I’m healthy!” population
- Services provided in multiple community locations and at Project Access NOW

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SDoH Framework

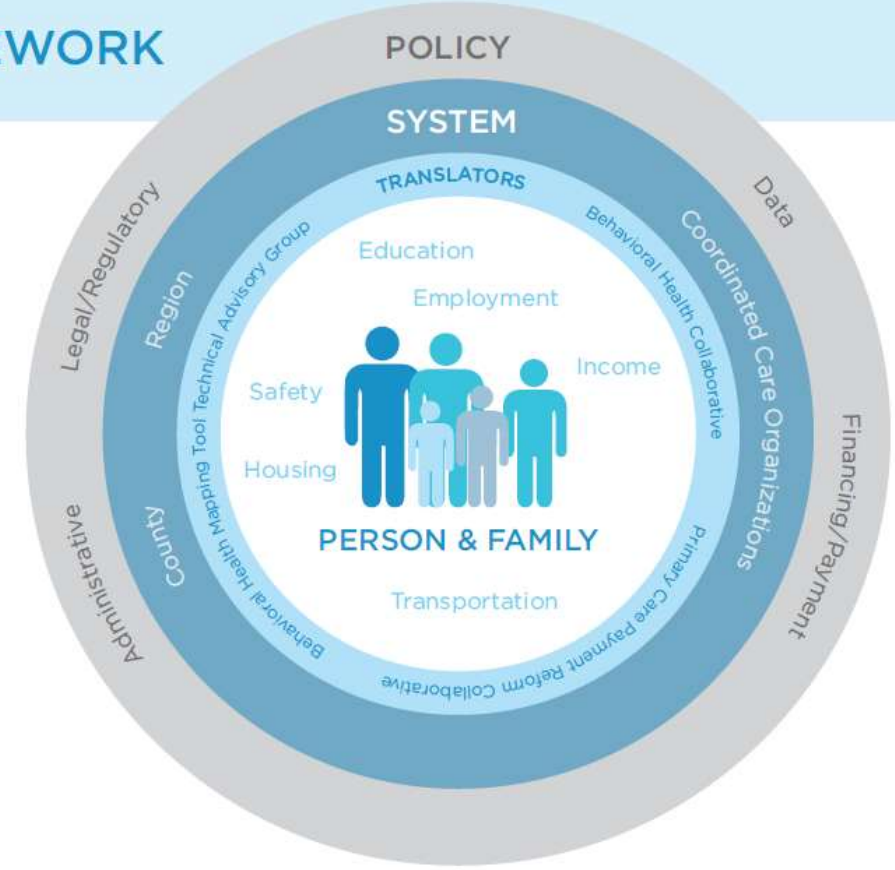
CONCEPTUAL FRAMEWORK

10% **Clinical Care**
Access to Care, Quality of Care

20% **Physical Environment**
Air & Water Quality, Housing & Transit

30% **Health Behaviors**
Tobacco Use, Diet & Exercise, Alcohol & Drug Use, Sexual Activity

40% **Social & Economic Factors**
Education, Employment, Income, Family & Social Support, Community Safety



EUGENE S. FARLEY, JR.
HEALTH POLICY CENTER

farleyhealthpolicycenter.org

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Community Pathways

Pathways Community HUB (national model) with demonstrated improved health outcomes and reduced costs

- ✓ Find - prioritized population
- ✓ Connect - coordinate and support connection to care and service
- ✓ Measure - results

- Network of partnering organizations
- Trauma informed , participant-centered, culturally specific navigation services
- Calls out 'navigation' as a function provided by multiple professions (CHW, SW, PS, etc.) that is accountable to the individual/family
- Supports clients in connection to cross sector needs and seeks to reduce duplication of data collection
- Implementation in partnership with social service providers and health care entities

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Community Delivery System

- Our community already has many existing resources/wisdom/trust - CBOs
- Current systems have historically served people of color inequitably and have demonstrated an absence of culturally competent services.
- We lack a coordinated community delivery system that intentionally *integrates* health, social services, and supports multi-agency collaboration.

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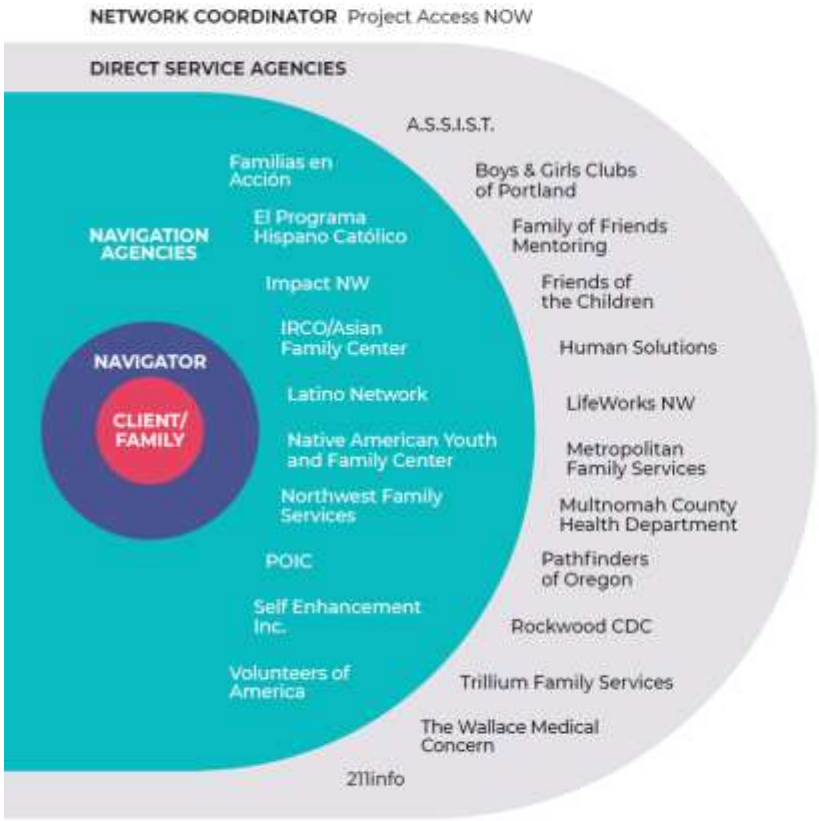
Community Pathways Network

COMMUNITY PATHWAYS NETWORK
REGIONAL COMMUNITY HEALTH NETWORK

NETWORK PARTNERS IN MULTNOMAH COUNTY



*Networks in Washington and Clackamas Counties are yet to be determined.

CORE VALUES

- Communities and families need resources that meet their unique needs.
- Equity is central to the Network.
- Client self-determination is conducive to client success.
- Quality assurance is an ongoing process that should incite change.
- The Network supports coordination and services centered on comprehensive needs of the individual and family.
- Transparency at every level increases the success of the Network.
- Attaining agreed upon outcomes is a driver to Network decisions.
- To be effective, we must be flexible and adaptable to changing environments and community need.

NAVIGATORS SUPPORT FAMILY SUCCESS THROUGH...

- Assisting in defining plans and goals.
- Providing meaningful connection to services.
- Sharing information.
- Maintaining ongoing communication and support services.
- Using a strength-based approach.

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Partnership with 211info

Why the partnership between **211info** and **Project Access NOW**?

- Navigators are connecting clients to wide array of social services
- Integration of 211info data into Clara allows navigators to track and document referrals and connections to services
- No desire to replicate social service data set
- Evolution of 'real time community resource directory' will be realized with partnership between **211info** and **Unite Us**

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What is different?

- The family is at the center of the network:
  - ✓ Multiple services that are more easily accessed by families – building on client trust, avoiding re-traumatization, etc.
- Each family has **one** Navigator that is responsible for assuring connections are made
- Shared Assessment
- Direct services will still happen in a variety of locations –with agreed upon information sharing to mutually reinforcing efforts
- Data is gathered consistently and payment for connective services are tied to meaningful outcomes for families and investors

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Regional Community Health Network

*** Vision and implementation for 2017 and beyond are currently in development**

- Leverage developed infrastructure to support broader networked approach
- Shared , secure community record of participants being served
- Support collaboration between social service and healthcare sectors
- Align with existing efforts (e.g. resiliency workers, early learning, community health worker's)
- Coordination of navigation vs service delivery
- Closed-loop referrals
- Robust social determinate data

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Want to know more?

Community Pathways
503.345.6720

Outreach, Enrollment & Access
503.345.7031

Premium Assistance
503.345.6576

Project Access NOW Classic
503.345.6553

Regional Community Health Network
503.345.6553

Community Assistance Program (C3CAP)
503.345.6732

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www.projectaccessnow.org

Social Determinants of Health

Presenter: Dan Herman, CEO, 211info

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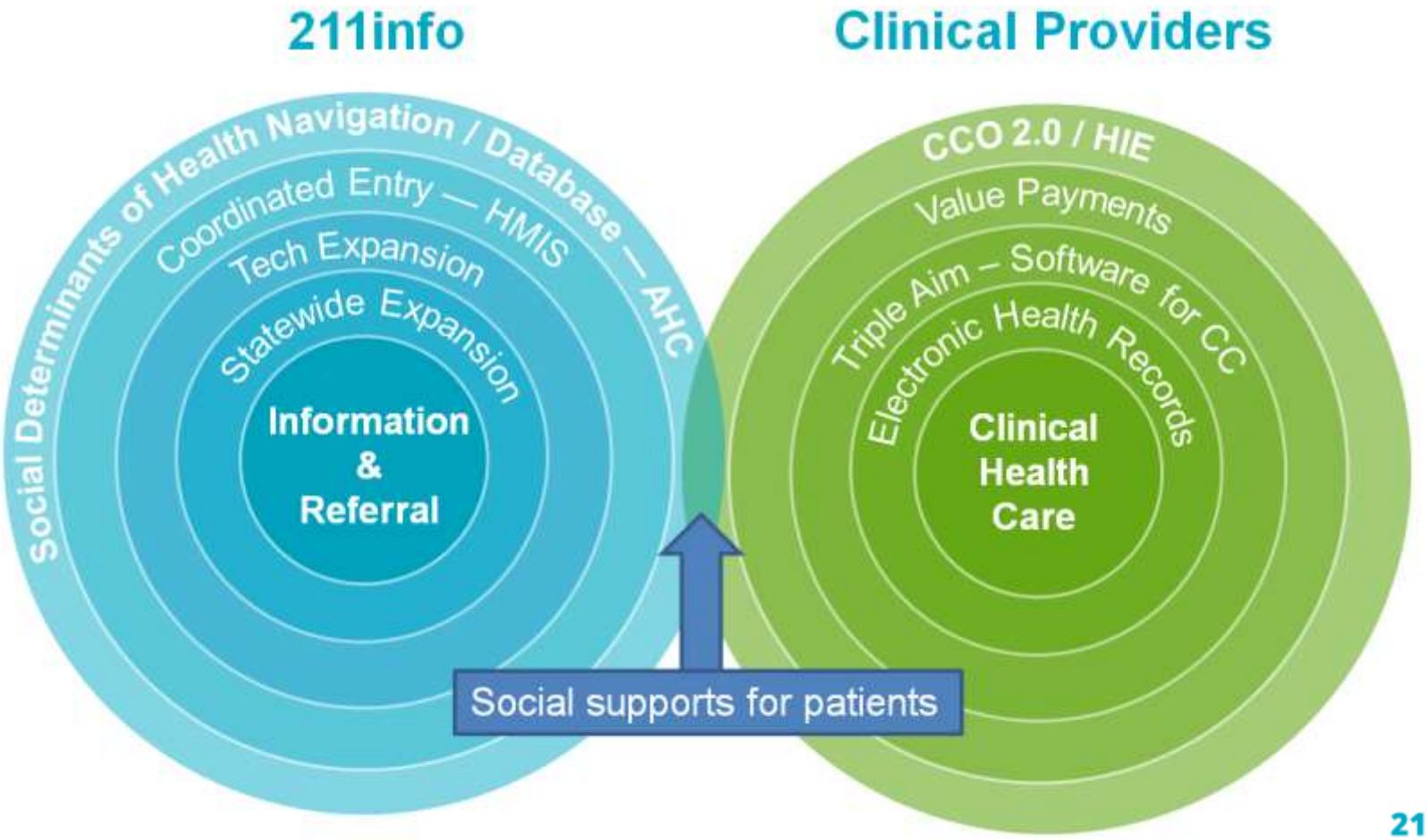
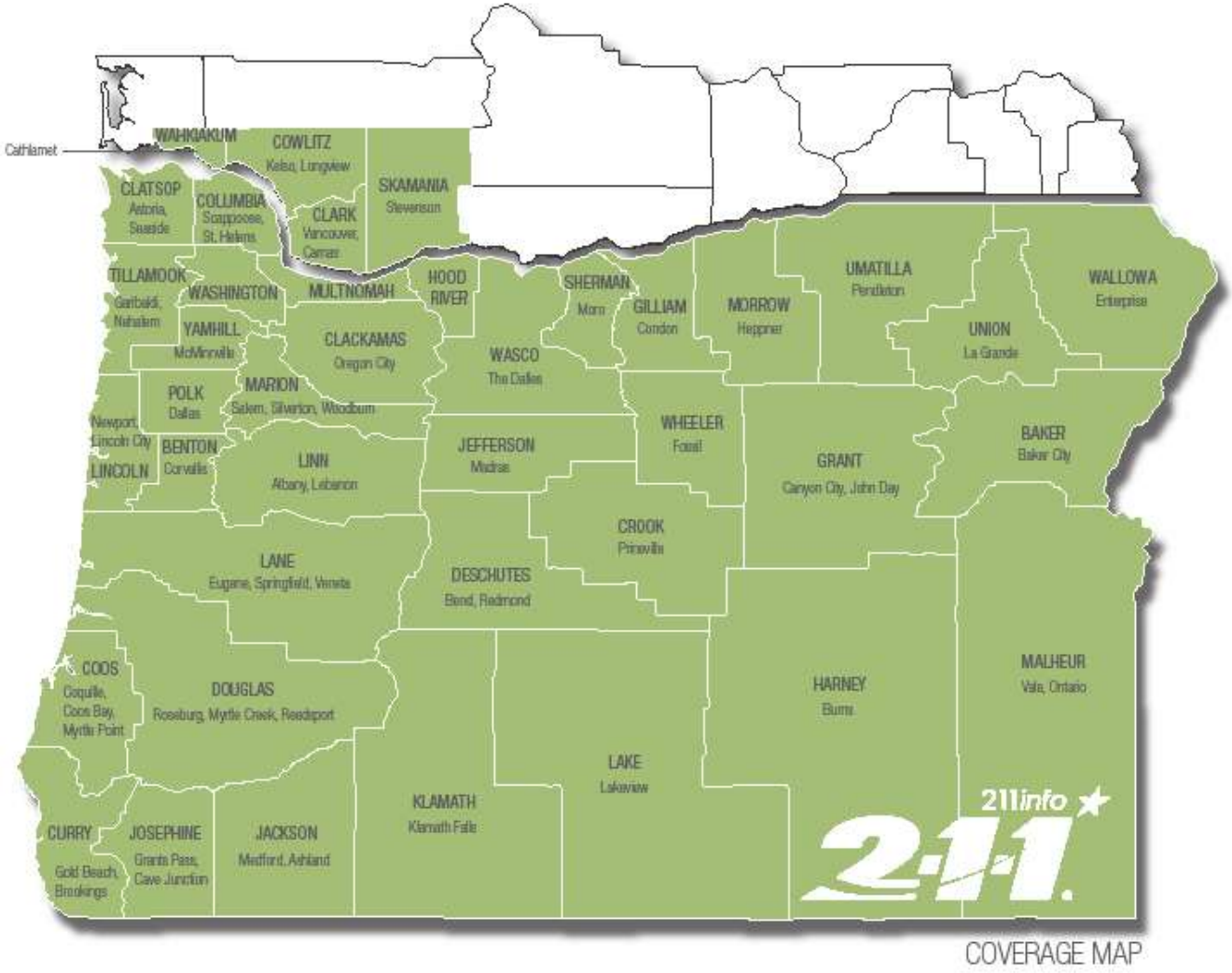
August 16, 2018

Begin with the End in Mind



211info – Coverage Area



700,000+ contacts per year

211info Overview

Channels

- ✓ Database accessed by phone call, text, email, mobile app and website 211info.org

AIRS

- ✓ Accredited by the Alliance for Information and Referral Systems
- ✓ 4.0+ satisfaction ratings with callers on a Likert scale

History

- ✓ Nonprofit crisis line formed in 1980; a health and social services referral provider since 2004
- ✓ In 2015, became sole source contractor for state of Oregon

211info Capabilities

Contact center

- ✓ Certified specialists, many bilingual
- ✓ High consumer satisfaction ratings
- ✓ Equity-focused and trauma-informed practices
- ✓ AHC navigation

Resource database

- ✓ Existing community partnerships
- ✓ 30,000 records meeting AIRS standards

Data analytics

- ✓ Sweet spot; growing function for 211info

Marketing and outreach platform

- ✓ Social media
- ✓ Community Engagement Coordinators

Good, Better, Best

Information and referral

- ✓ Database of 30,000 records and certified specialists
- ✓ Anonymous contacts and aggregated data reports

Coordinated entry

- ✓ Housing programs, using database and HMIS (Homeless Management Information System; HIPAA compliant) that meet federal data confidentiality and reporting requirements
- ✓ Specialty programs

Navigation/care coordination

- ✓ Health care environment, with resource management, needs assessments, closed-loop referrals
- ✓ Data reporting and analytics and new technology platform
- ✓ Leveraging AHC work
- ✓ MOU with Unite Us

Data Capabilities

211info Medicaid Contacts

State of Oregon, July 2017 – June 20180

Top Health-Related Need Requests	Number of contacts
Aging and Disability Resource Centers	**989**
Domestic Violence Hotlines	**301**
Glasses/Contact Lenses	**216**
Medicaid	**137**
Mental Health Evaluation	**127**
Eye Examinations	**112**
Emergency Dental Care	**99**
Dental Hygiene	**80**
Community Clinics	**78**
Dental Care Referrals	**76**

Top Basic Need Requests	Number of contacts
Rent Payment Assistance	**5,494**
Electric Service Payment Assistance	**4,789**
Community Shelters	**2,985**
Low Income/Subsidized Private Rental Housing	**2,694**
Rental Deposit Assistance	**1,731**
Transitional Housing/Shelter	**1,393**
Child Care Provider Referrals	**1,318**
Food Pantries	**1,131**
Food Stamps/SNAP	**793**
Housing Search Assistance	**687**

Demographic and needs assessment data consumed by elected officials, policy makers, CCOs and HIE

211info's Health Care Role

- ✓ **AHC-CMS** – Accountable Health Communities
- ✓ **RCHN** – Regional Community Health Network (CLARA)
- ✓ **SWACH** – Southwest Washington Accountable Community of Health
- ✓ **Informal referrals** from clinical providers
- ✓ **Specialists** – ScreenWise, Komen, MCH
- ✓ **MOU** with Unite Us

211info's Role (AHC-CMS)

211info's role is to provide **actionable information** on **locally accessible social services**, provide **navigation services** (inbound and outbound calls) **in support of improved health outcomes**

Participating counties:

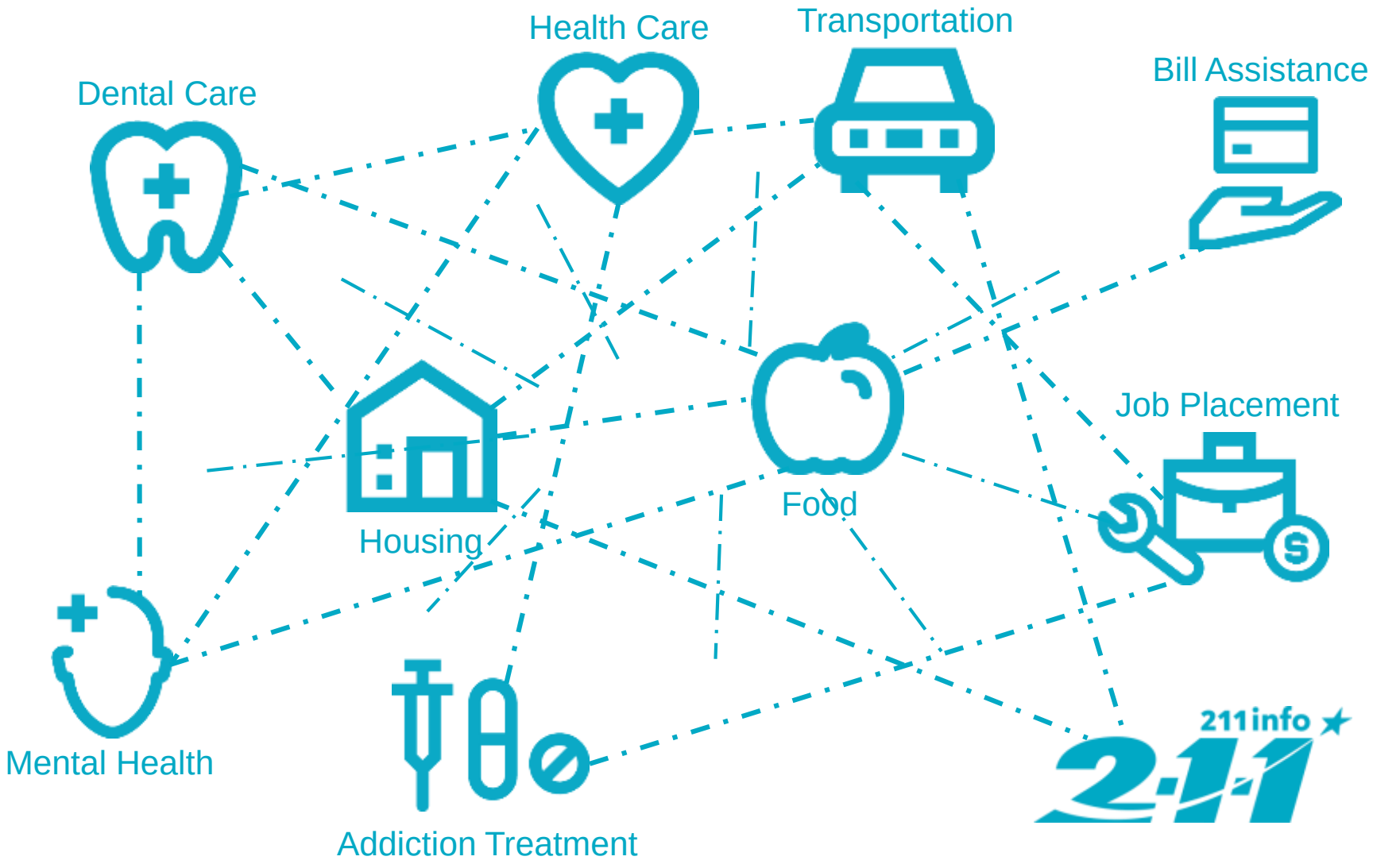
- ✓ Curry
- ✓ Crook
- ✓ Deschutes
- ✓ Hood River
- ✓ Jackson
- ✓ Jefferson
- ✓ Josephine
- ✓ Wasco
- ✓ Yamhill

The value of technology innovation in SDoH

Tech platforms like Unite Us are modernizing the way healthcare providers can 'prescribe' social service supports. These tools:

- ✓ Screen patients for unmet needs
- ✓ Identify relevant local social service resources
- ✓ Allow closed-loop referrals for accountability and improved outcomes
- ✓ Store data for analysis

Data Interoperability



Community Information Exchange (CIE)

- **San Diego consortium project:** led by 211 San Diego for the past 10 years: San Diego County, Health Systems, Law Enforcement, Clinical and Social Service Providers, San Diego Health Connect (HIE)
- **CIE functions:** an EHR that's focused on social services: portable, universal, patient/client centric, HIPAA driven, shared by CBOs, seeing a reduction in spend across high-utilizers
- **Common goals:** shared measurement, mutually reinforcing activities, continuous communication, hub support
- **For more information:**
  https://211sandiego.org/community-coordination/

Small Group Discussions

1. How far past the clinic walls and into the community does the clinic need/want to follow a patient's SDoH needs/resolution?

2. How can community-based organizations embed with health care providers, and vice versa?

3. What information is needed between health care and community service providers so meaningful data can be collected, analyzed and used to guide resource allocations, workflow, etc.?

4. How can we manage privacy and security issues?

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