Weaving people into service delivery: Our journey in walking beside others to implement PRAPARE

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Community Health Centers of Benton & Linn Counties

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Benton County Health Services

"Healthy People In A Healthy Community"
Benton County Oregon
Health Department

Benton County Oregon
Mental Health

Community Health Centers of Benton & Linn Counties

Public Health

- Communicable Diseases
- Home Visiting
- Family Planning
- Healthy Communities

Environmental Health

- Inspections/codes
- Preparedness

Developmental Diversity

- Individual Supports
- Case Management

- Assessment
- Individual/Group Therapy
- Case/Medication Management
- Peer Specialist Support
- Client-Centered Service Planning
- Psychiatric Services
- Assertive Community Treatment
- Crisis Services

Community Health Centers of Benton & Linn Counties

Focus on health equity and integration of services across the continuum.

Community Health Centers

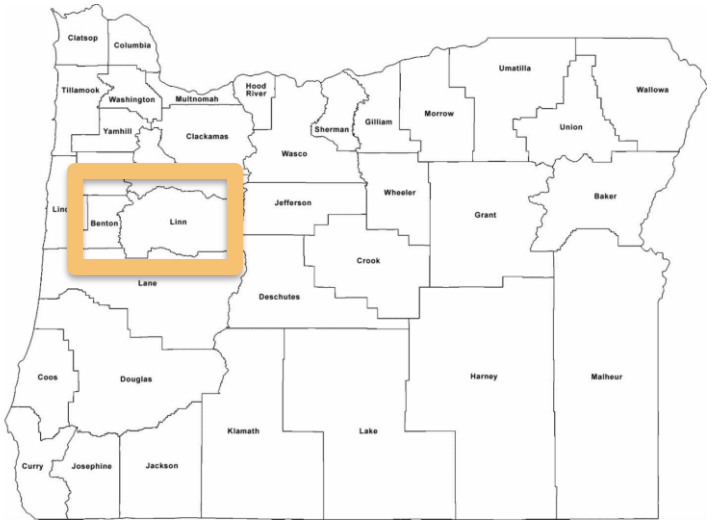
Public entity Federally Qualified Health Center

Benton and Linn Counties

- 7 clinic sites
- Patient-centered, team-based care
- Integrated primary care: physical, oral, behavioral health services



Our Counties (briefly)



Benton County

92,000 residents

- 66% in Corvallis (61,000 people)
- 19% rural areas

Ranked 3rd in Overall Health Outcomes

Linn County

124,000 residents

- 37% Albany (46,000 people)
- 32% rural areas

Ranked 19th in Overall Health Outcomes

Community Health Centers of Benton & Linn Counties

We hope to share our…

Growth in **Health Navigation**

- Role in our community and the benefit to health services

Use of **Human Centered Design**

- Culture changes and tweaks, versus bulldozing

Implementation **Supports**

- CCO opportunity for delivery system transformation

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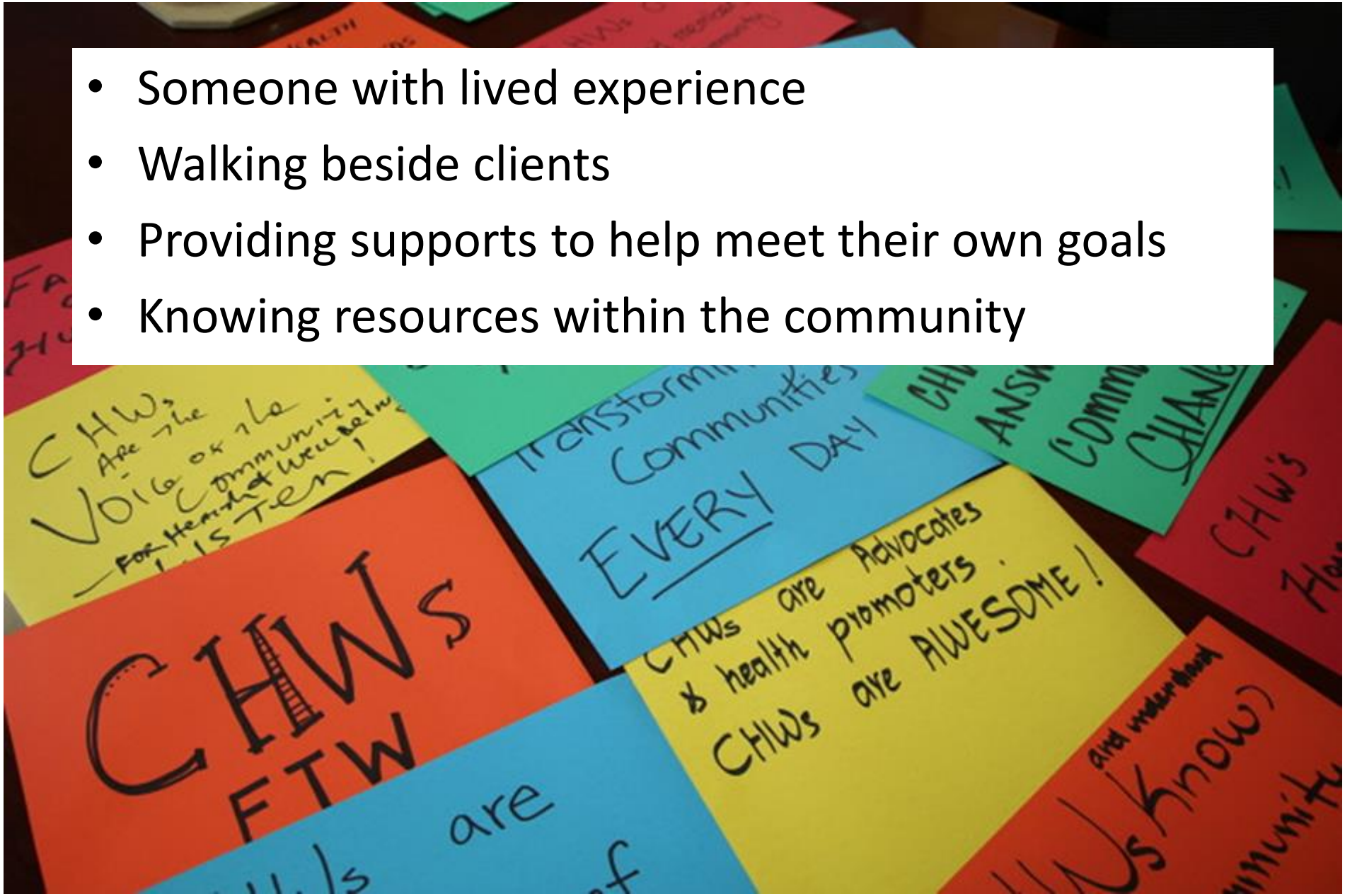
Benton County Health Services Health Navigation Program

The work…



- Someone with lived experience
- Walking beside clients
- Providing supports to help meet their own goals
- Knowing resources within the community

Why do the work?

1. Better Health

2. Better Care

3. Lower Costs

4. Health Equity

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Our Program Growth

2008-

One grant-funded, part-time Community Health Worker/ "Navigator"

Today…

26 Community Health Workers who work as "Health Navigators"

- 20 bilingual-bicultural Spanish
- 1 bilingual-bicultural Arabic
- 5 monolingual English

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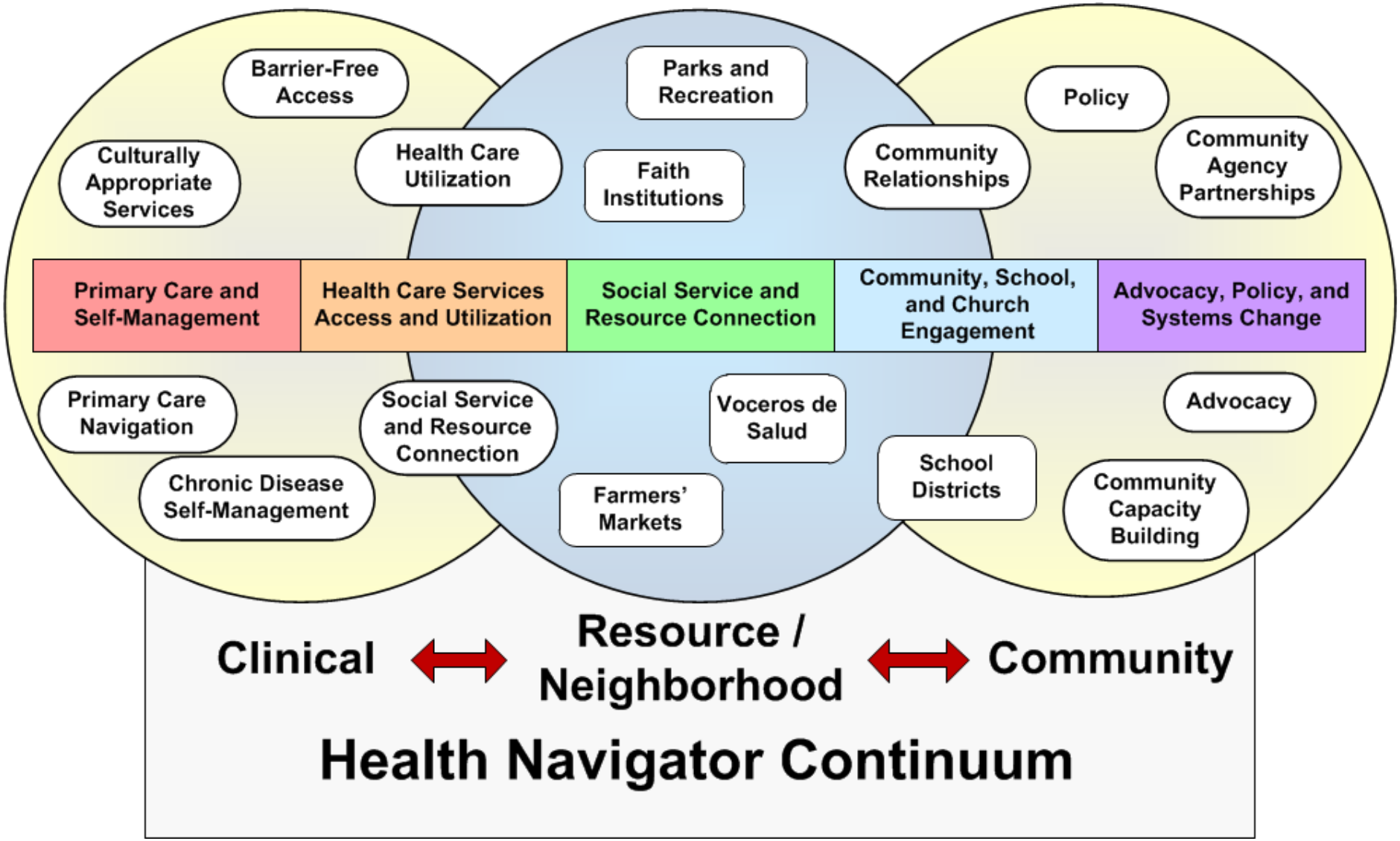
How we do the work…



What Clinical Navigators do

- Part of the care team alongside the RNCC, Behaviorist, Providers
- Teach self-management of chronic diseases in English and Spanish
- Resource navigation
- OHP enrollment and financial assistance

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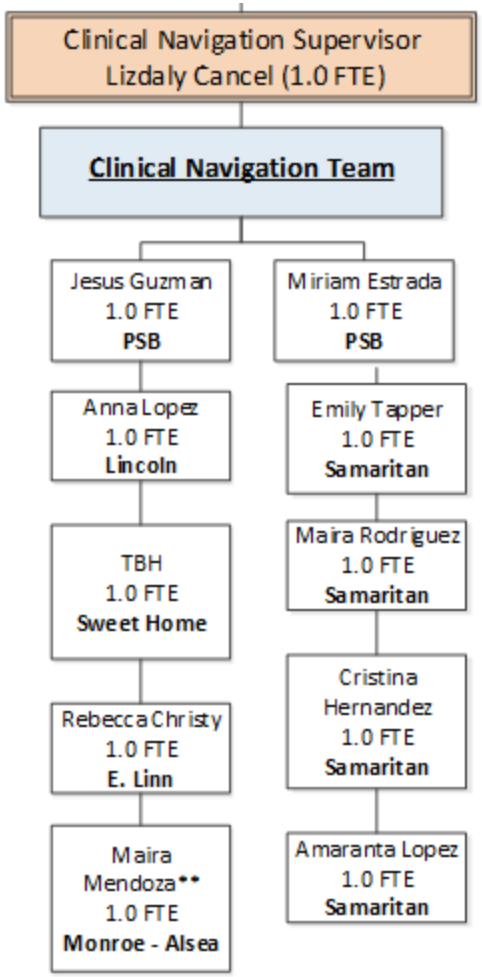
Where Clinical Navigators work

11.0 FTE

1- Supervisor

6- Coverage for each of the CHC clinics

4- Samaritan Health Services clinics



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What Outreach and Enrollment Navigators do

- OHP enrollment, renewals, and everyday assistance
- Oregon Mothers Care enrollment
- Outreach work in Benton and Linn counties
  - 93 events in 2017

January- November 2017

14,508 “touches”/Care STEPs

3,427 OHP applications

2,204 new

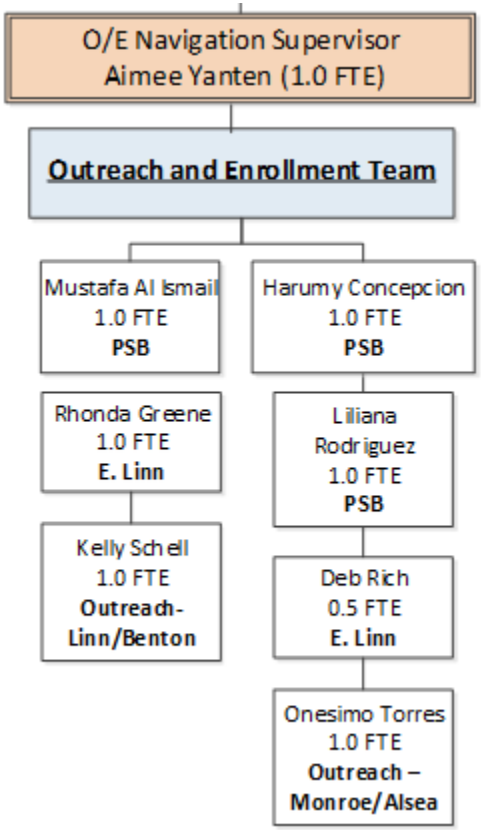
1,223 renewal

5,672 individuals

Where Outreach and Enrollment Navigators work

8.0 FTE

1- Supervisor
5- Outreach and Enrollment team
2- In the community with partners
    like DHS, Parole and Probation,
    variety of social services



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*Everyone on the Health Navigation team is first trained and certified as an OHP enroller

What Community Navigators do

Language Services

- Interpretation and translation for the organization and community

Oral Health Navigator

- Coordinating services with in schools, residential living facilities/Veterans' Home, WIC, Boys & Girls Club clinic

Social Determinants of Health Pilot

- Working to implementing PRAPARE

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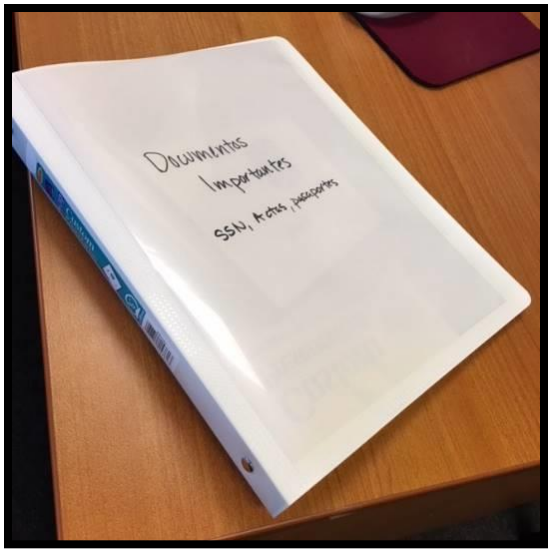
What School Navigators do

- Inside school building
- Resource navigator for students, families, and area
- Referrals to health center, mental health, social service, Parks and Recreation, food sources, advocacy



<u>2016-2017 school year</u>

5,215 total touches/Care STEPs

<u>2017-2018 school year (July-November)</u>

1,969 touches/Care STEPs

Where Community Navigators work

7.0 FTE

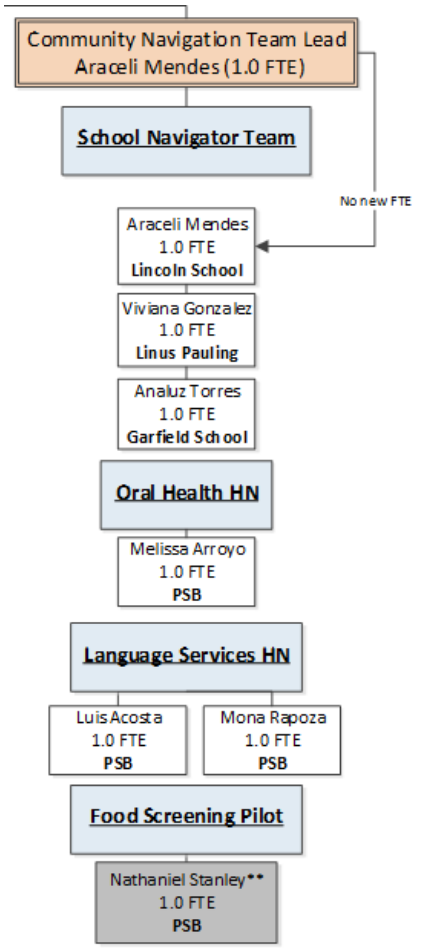
Team Lead

3- Schools (elementary and middle)

1- Oral Health

2- Language Services

1- Food Screening Pilot (limited duration)



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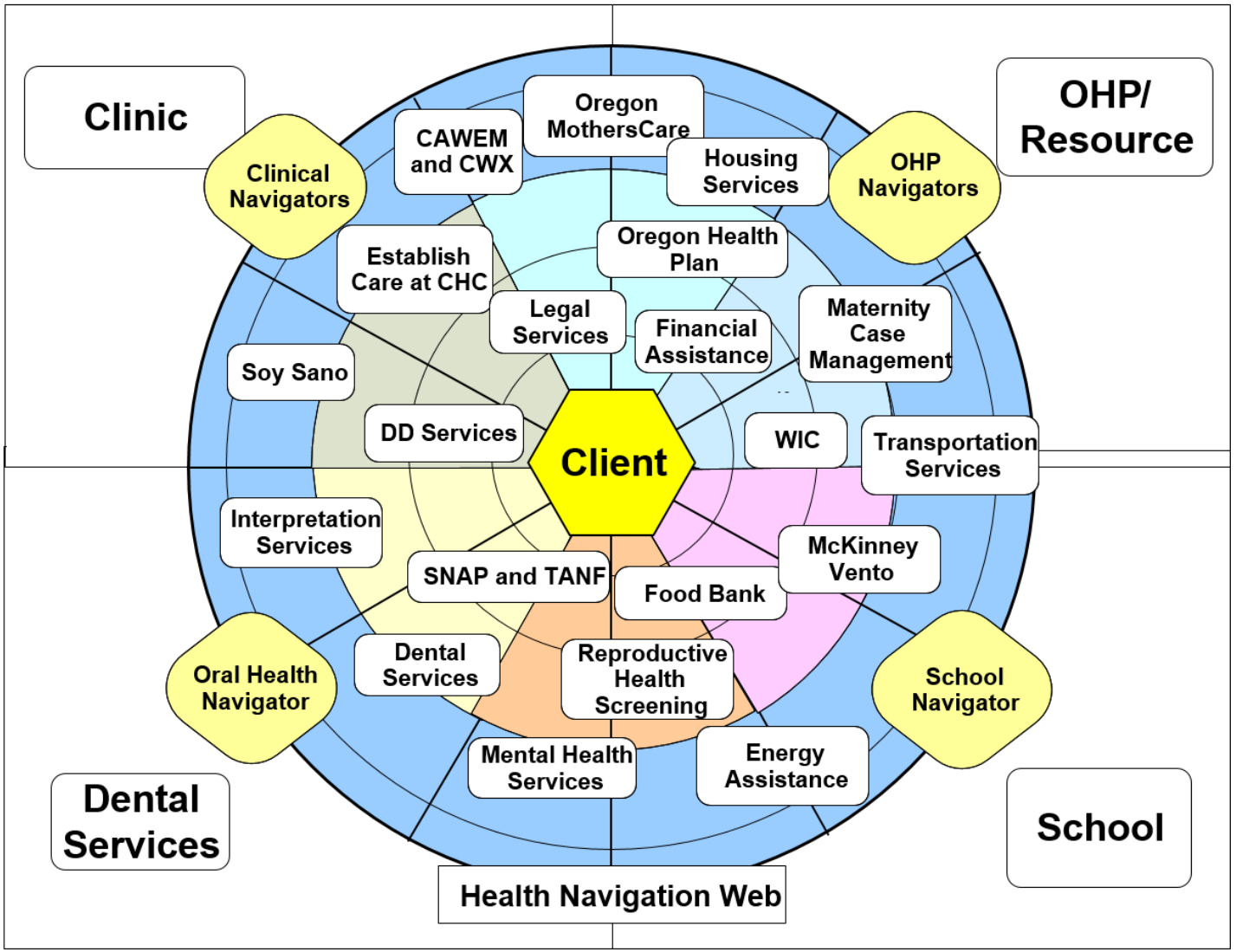
Woven Net of Client Care



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On Deck: Training Hub Pilot

Making Certification Accessible

- BCHS is the “backbone agency”
- Modifying an Oregon Health Authority (OHA) approved curriculum
- Training new Community Health Workers who can then be “certified” by OHA
- Still need to be trained to do agency-specific work

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Contributions to Success

- Leadership support
- Delivery System Transformation opportunities
- Strong community partnerships
- Community need

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Our Motto

Even if we can't get our clients everything they need, we can always leave them with three things:

Having been seen, heard, and respected.

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INHALE,

EXHALE,

Y

REPITA

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Center for Care Innovations

- California based social venture with support from foundations (Blue Shield, Kaiser)
- Connects safety net providers with solutions, resources, and experts to accelerate innovations for healthy people and healthy communities

We spread solutions. We test ideas. We build community.

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Catalyst Program

Cultivate a community of innovators who are using design thinking to co-create the future of the safety net.

Oregon Clinics who have participated:

- OPCA
- CHC Benton/Linn Counties
- Virginia Garcia
- Yakima Valley
- Central City Concern
- Rinehart

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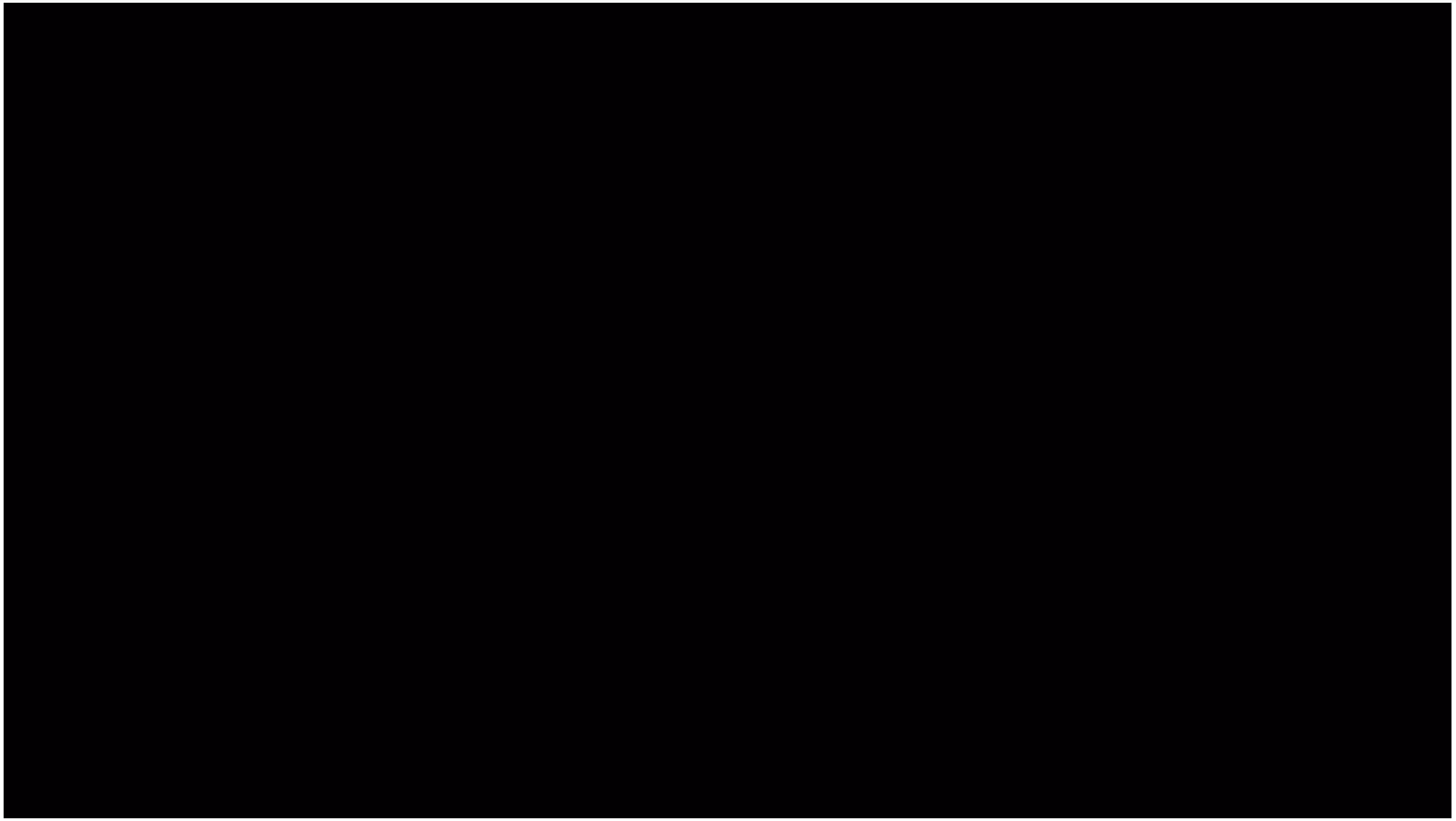
catalyst

Freedom Support Encouragement



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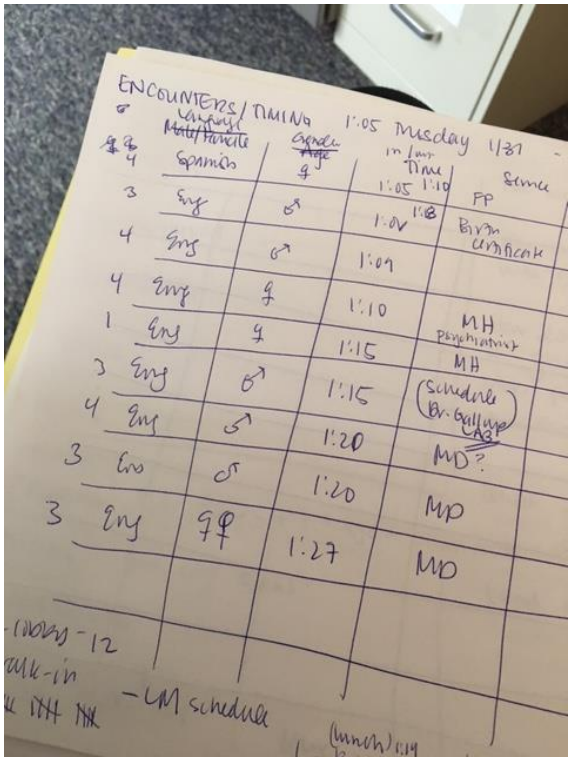
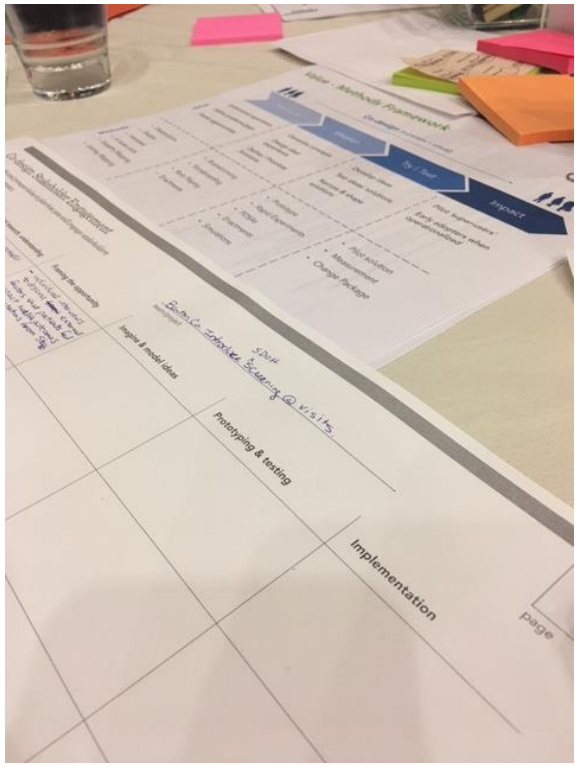
Our Catalyst Project

See and Experience



Question and Reframe



Dimension and Diagram

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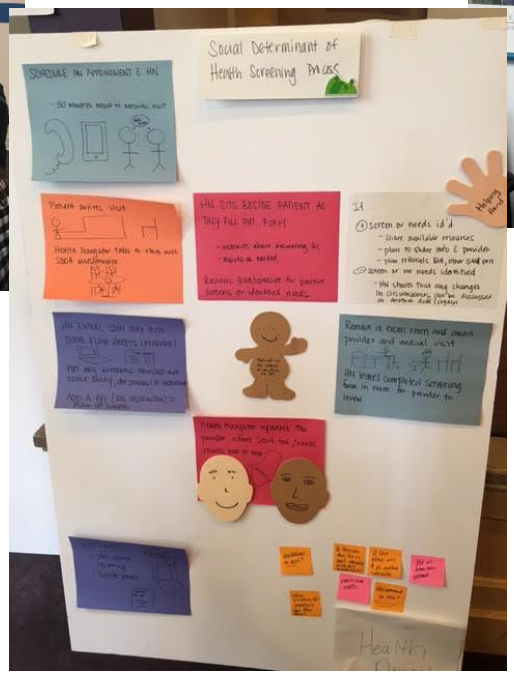
Catalyst Process, Continued

Imagine and Model

Pitch and Commit



Test and Shape

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‘Screening for Social Determinants of Health opens a door to a larger conversation, about a core issue of a person’s basic needs not being met. It is Trauma Informed and helps people to see that we are walking with them in their journey.’

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Food Security Screening Pilot

July 2017- December 2018

- Hired Health Navigator
- Trained Health Navigator
- Implemented a 3 month PDSA Well Child Checks
    - School Based Health Center
    - Lifestyle medicine provider
- Talked with High Complexity Care team
- SDOH Workgroup

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Corvallis Environmental Center

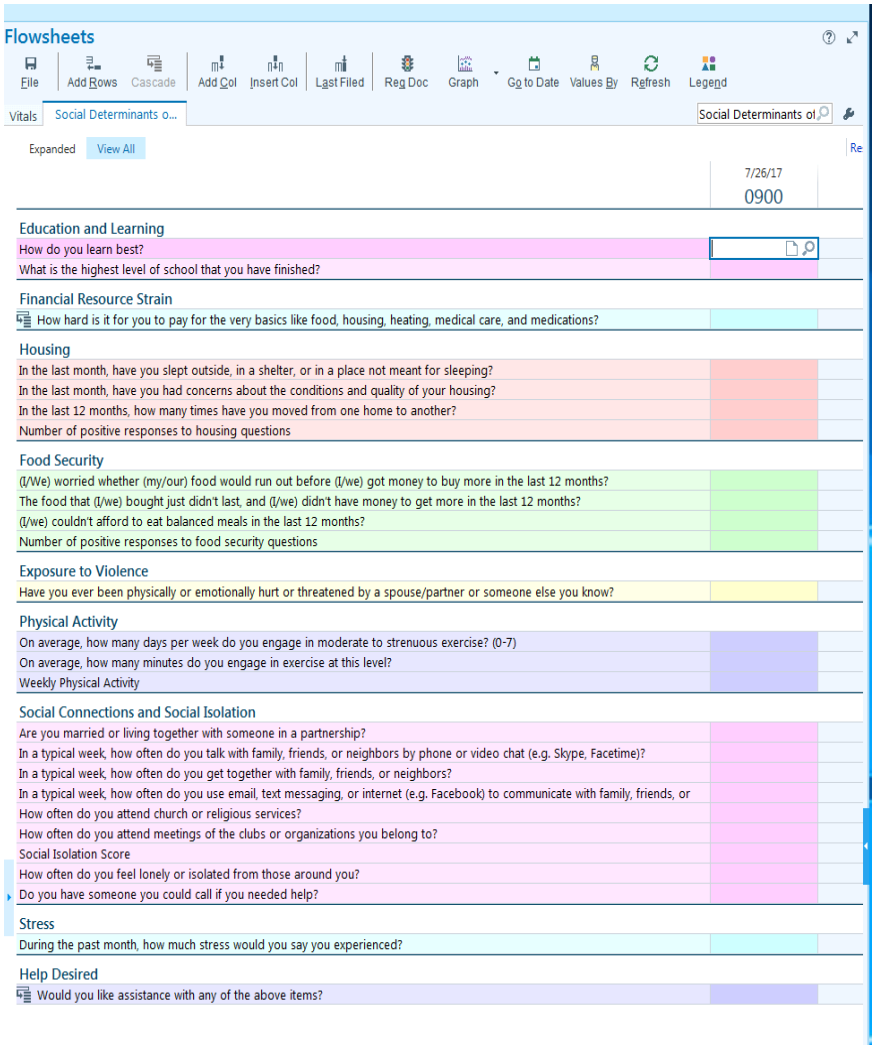
InterCommunity Health Network CCO

PRAPARE* tool

*Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Considers

- Learning Style
- Financial Security
- Housing
- Food Access
- Safety
- Physical Activity
- Social Connectedness
- Stress



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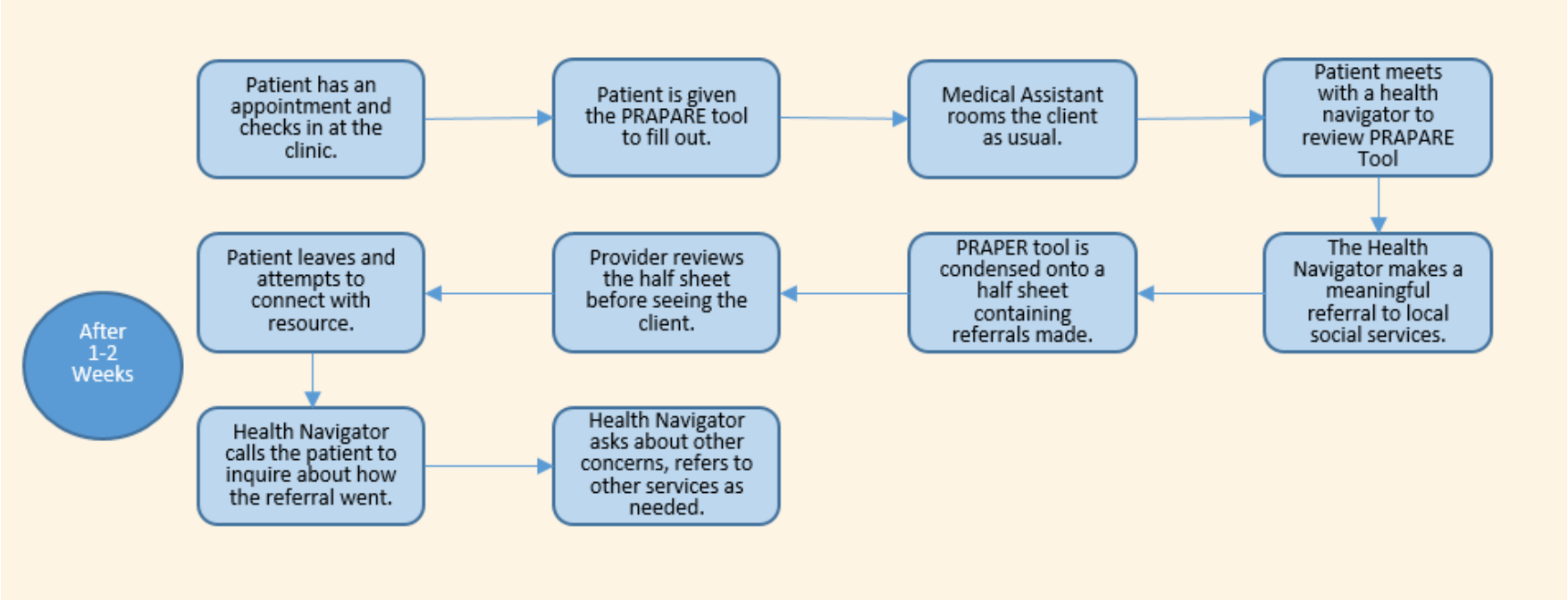
Current Workflow



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Team-based care environment

Working in this area now…

Health Navigation

RN Care Coordinators

Behavioral Health Consultants

Clinical Pharmacists

Panel Managers

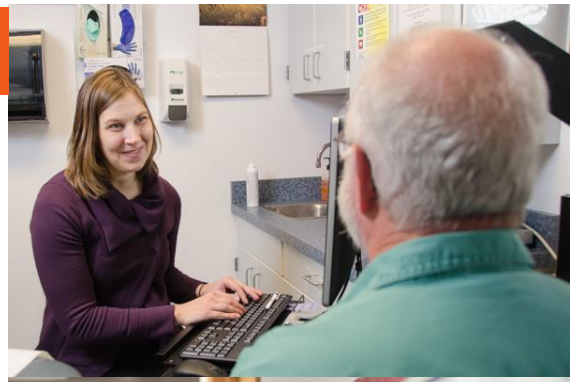
Providers

Supporting the work…

Client Services Representatives

SOS Team

Managers/Leadership



OPCA Assessment Work

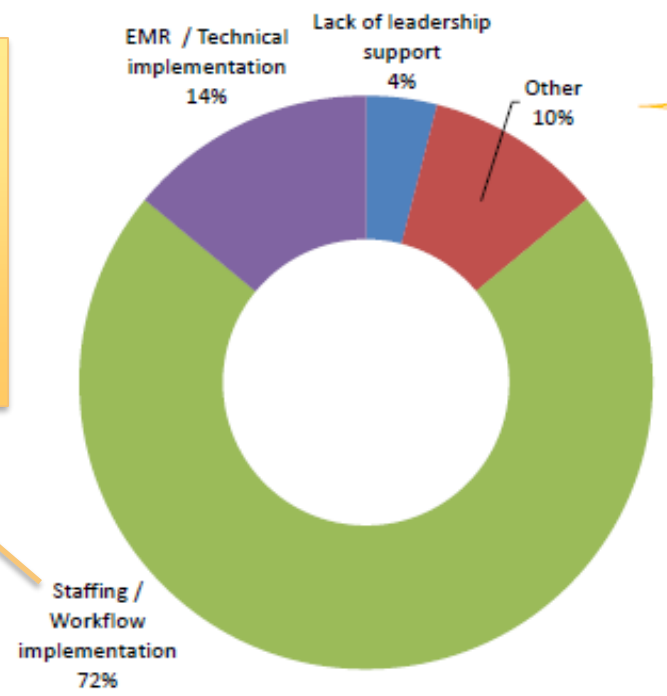
Fall 2017

- 26 clinics (54 responses)
- How CHCs in Oregon are assessing and addressing the SDOH in their patient population

OPCA Oregon Primary Care Association

Leading barriers to screening patients for SDH

Staffing/workflow implementation



- PRAPARE tool is cumbersome
- Getting all staff on board
- Uncertainty of what to do with the data
- Needing resources to send patients to
- Challenge of casting a wider net to ALL patients

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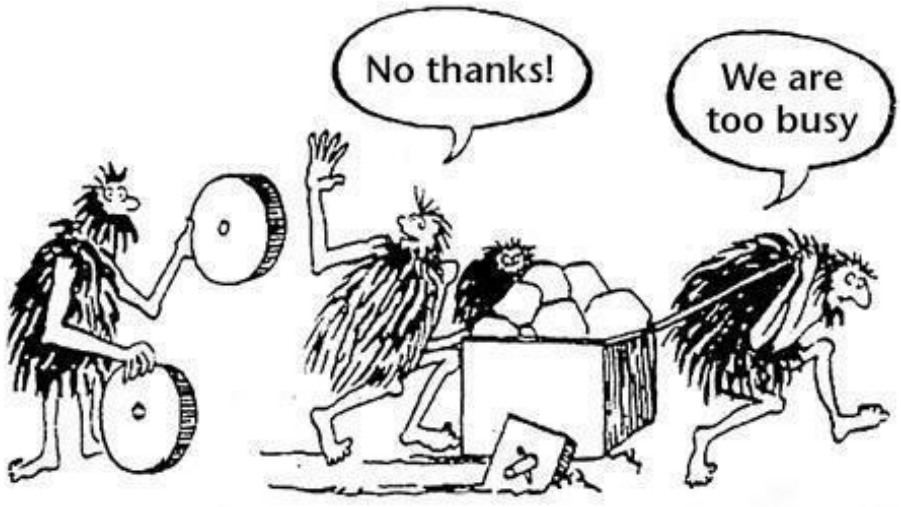
The Social Determinants of Health Academy



Culture

- Resiliency
- Management

Operations

- Staffing
- Systems

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http://medical-legalpartnership.org/events/sdoh-academy/

Importance of Data

Identify trends

Tell the story

Engage additional partners

Data can be pulled from OCHIN flowsheet

Exported into Excel

Analyze for trends and outliers

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Past Findings

Fall 2016 N=72 3 clinics

Nearly 60% of people had a somewhat hard time paying for basics

The hardest things to pay for were:

51%

49%

43%

65% were Food Insecure- 47 people

54% were lonely or isolated- 3 people responded Always

24% experienced a lot of stress

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Current Findings

Winter 2017 N=18 1 clinic, Well Child Checks

Two-thirds:

- High school/GED or less education
- Find it hard to pay for basics (utilities, transportation, medical, rent, food, clothing)

4 flagged housing concerns
6 flagged food security
10 social isolation score

61% reported meaningful stress

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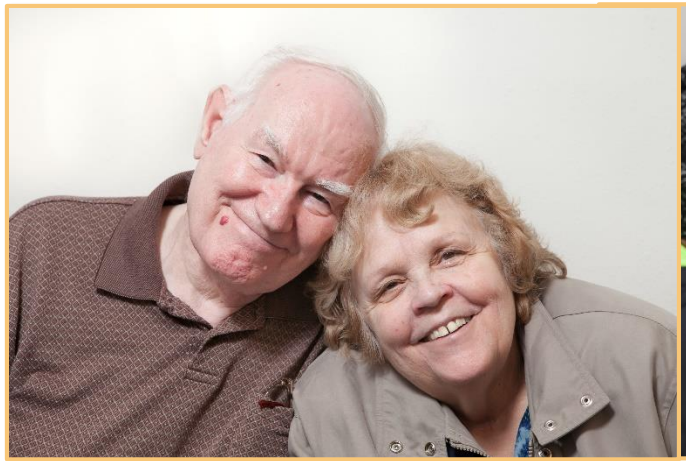
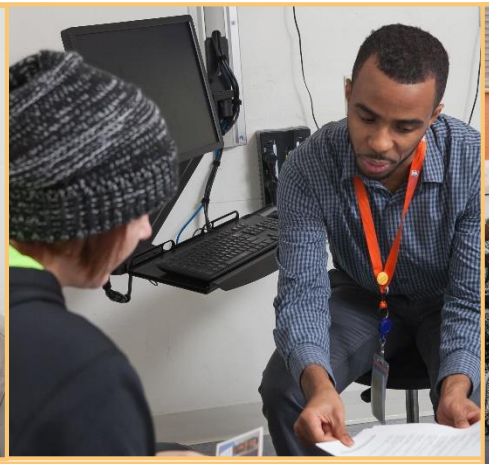
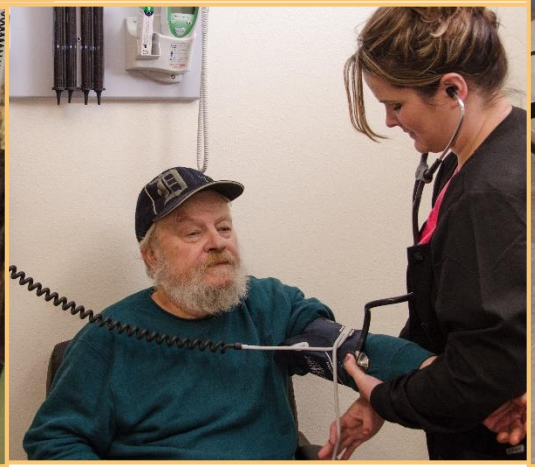
From the Field







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‘We have some struggles’

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‘Especially if I don’t get my deer…’

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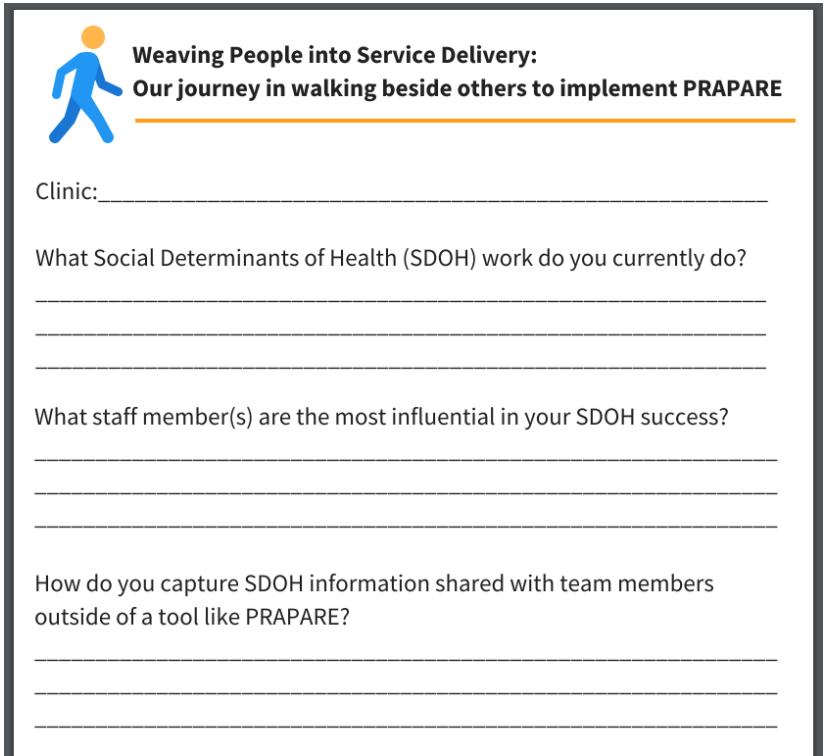
Tell us your story

On your table there is a handout

Clinic
Current work
Staff influences
Tools



Weaving People into Service Delivery:
Our journey in walking beside others to implement PRAPARE

Clinic:_____

What Social Determinants of Health (SDOH) work do you currently do?

_____
_____
_____

What staff member(s) are the most influential in your SDOH success?

_____
_____
_____

How do you capture SDOH information shared with team members outside of a tool like PRAPARE?

_____
_____
_____

Community Health Centers of Benton & Linn Counties

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