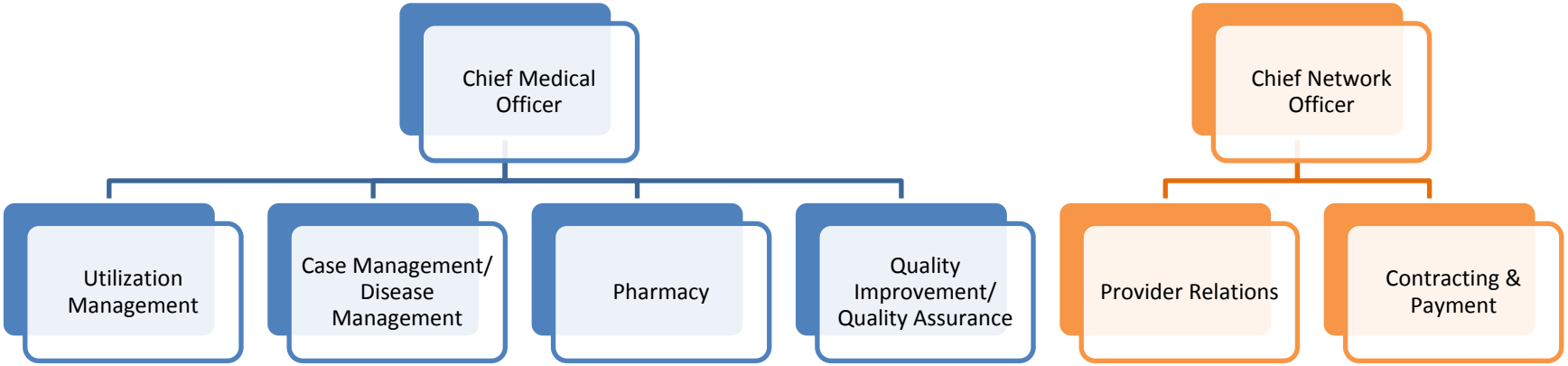
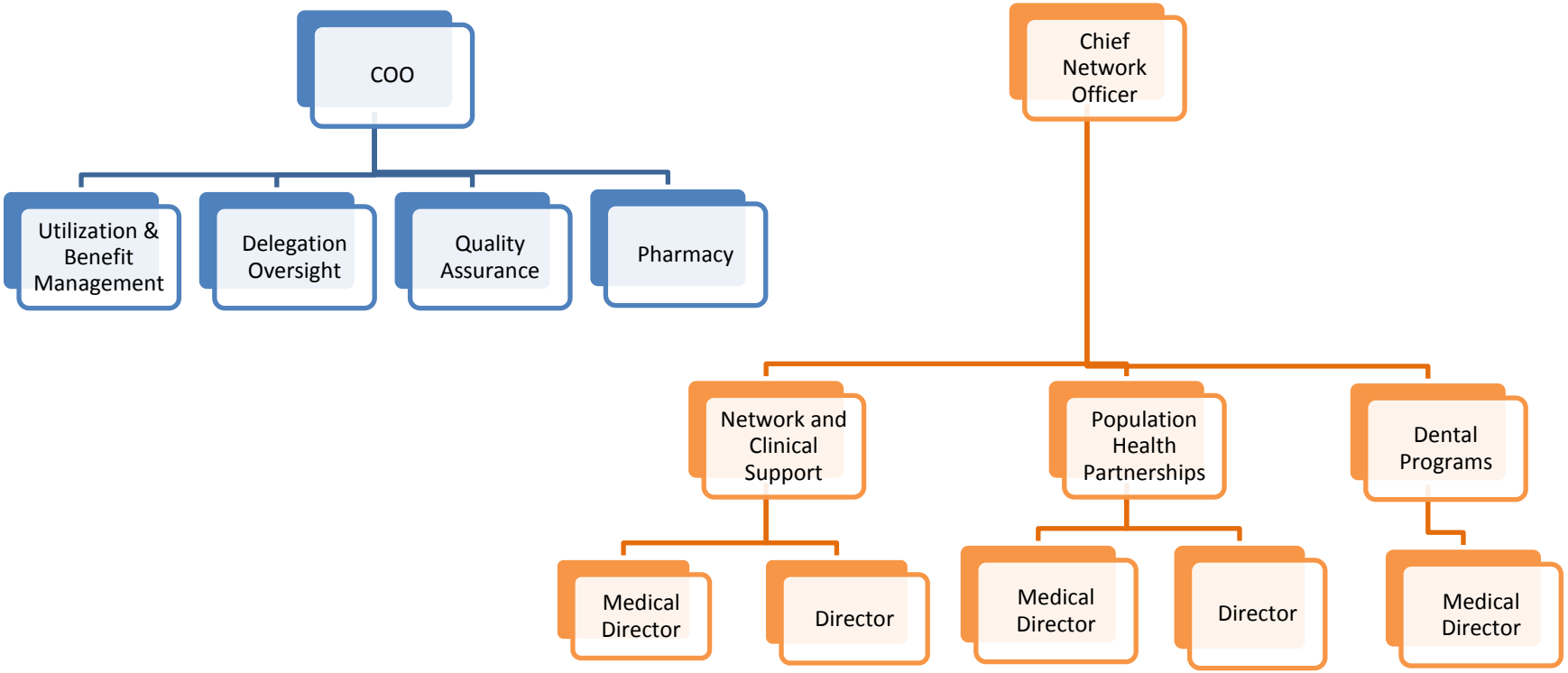
Taking Care to our Members:
Population Health Strategies for Vulnerable Beneficiaries

Rebecca Ramsay, BSN, MPH
Director – Population Health Partnerships

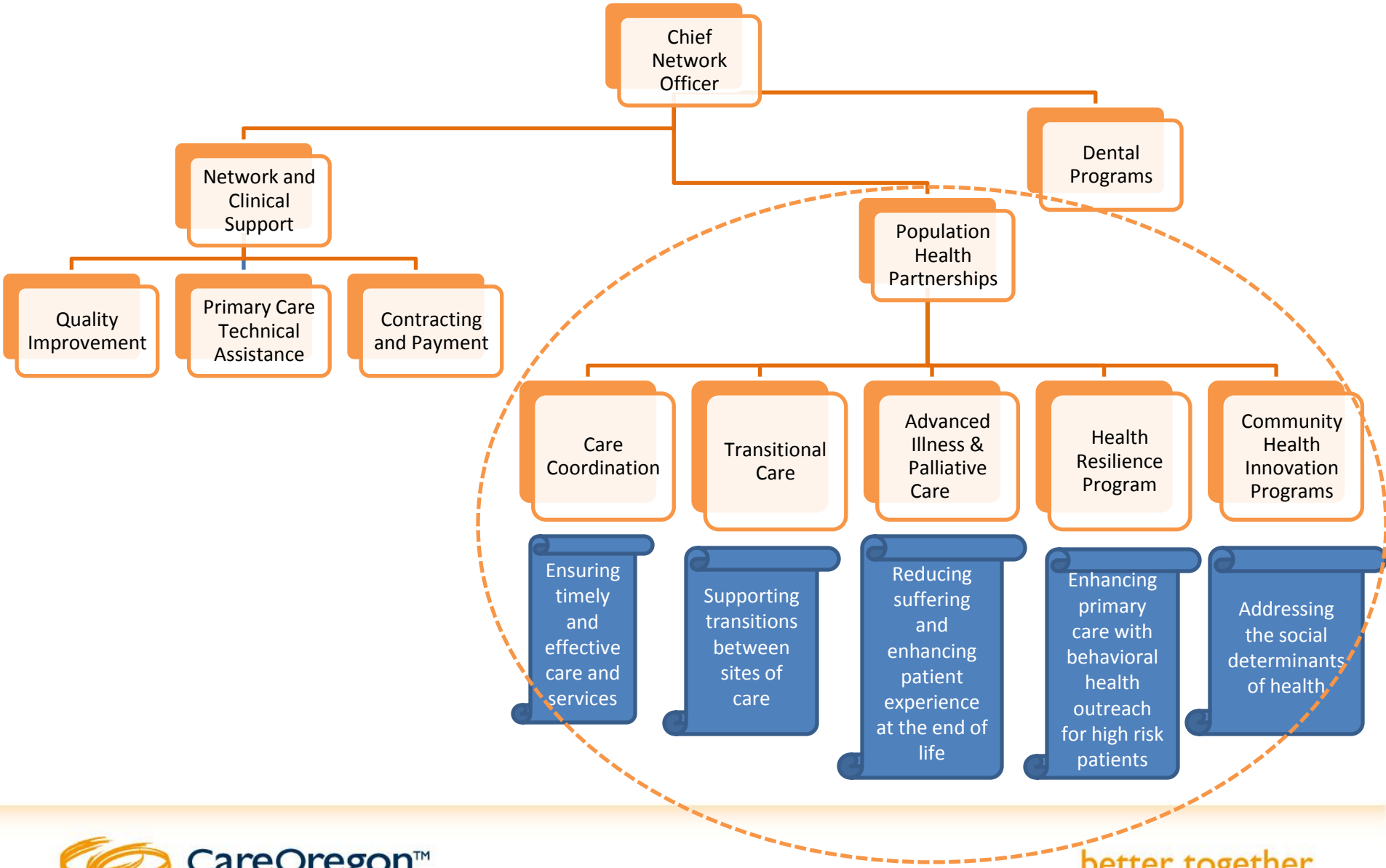
Typical Health Plan Org Structure



A New Structure to Enhance Population Health Outcomes



CareOregon's Population Health Programs

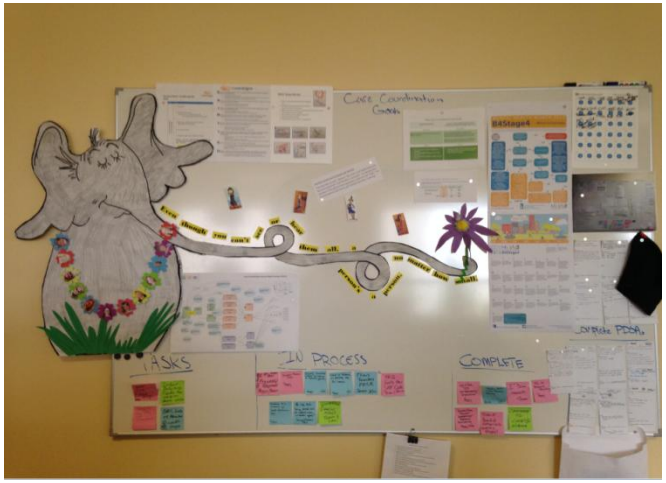


Care Coordination Program

Purpose: To assist members in obtaining needed services and to coordinate care between our health plan and our community partners.

Care coordinator's assist our members with:

- obtaining an effective primary care home
- using their benefits optimally
- discharge planning needs
- connecting to needed specialty services, DME, community services and non-plan benefits that may be important components of overall health care.



"We are the Horton who hears every who….."

Our care coordination program is multi-disciplinary and is comprised of nurses, BH specialists, and care coordination assistants that are assigned to our four CCOs, and further aligned with particular primary care providers and hospital systems.

Transitional Care Programs

Who are the Teams?	Who do we serve?	Medical	Social
RN, BHS, Pharmacy Embedded 2 hospitals 4 clinics	Members at "friends and family" clinics	• Discharge coordination • Self-management • Follow up with outpatient care • Medication management • Primary Care engagement	• Discharge coordination • Referral to community based services • Mental health engagement
RN, BHS, Pharmacy Internal Located at CareOregon	Members at small clinics, and/or living outside of Tri-County area		

Better care, better health, reduced hospitalizations, continuity across systems

Advanced Illness/Palliative Care Programs

Definitions:

- Hospice= six months to live
- Advanced Illness= end stage disease, often with 1-2 years to live
- Palliative Care= Standard of Care for Anyone with a Life Limiting Illness
- What is Palliative Care?
  - Care Coordination
  - Symptom Relief
  - Shared Decision Making (Advanced Care Planning)

Safety Net/Dual Eligible Palliative Care

Population Considerations:

- Traumatized Population with Addiction, Mental Health, Housing Risk, Isolation
- Patients Often Decades Younger
- Lower Health Literacy affects Advance Care Planning
- Therefore, Relationship Based Care is Key
- Many patients will never choose hospice

Specialized Goals:

- Integration of traditional palliative care skills with population specific approaches: trauma informed care, motivational interviewing, awareness of addiction/mental health factors
- Bring palliative care skills and mindset into primary care setting
- Integration into primary care team instead of specialized service

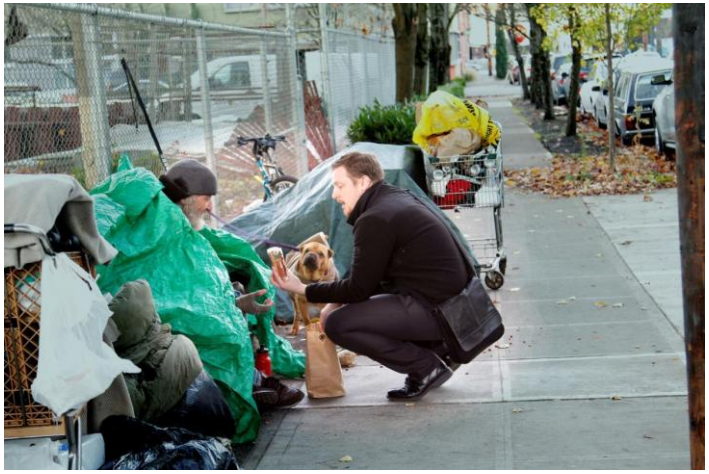
Palliative Care/Advanced Illness Program Design Pilots

In the next 3 months, CO will be launching two pilot demonstrations that will include a primary care clinic partner and an outpatient palliative care partner.

- In each setting, palliative care partner will provide a palliative care RN & SW to work with CareOregon members and CareOregon will provide a palliative care pharmacist
- CareOregon will provide innovative payment models, specialty training opportunities, and a learning collaborative to promote adoption, spread, and scale.

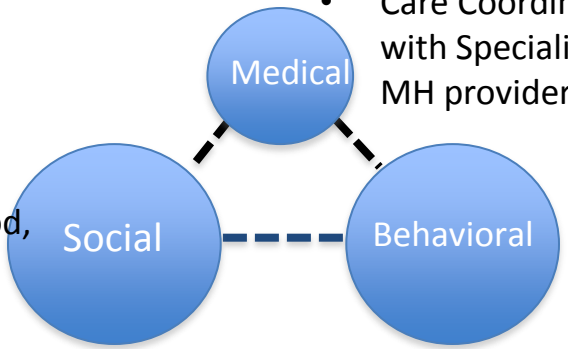
Health Resilience Program

Health Resilience Specialists (Master's level Social Workers) are **embedded** with **primary health homes** and specialty practices to **enhance** the practices' ability to provide community-oriented **individualized 'high touch'** support to high risk/high cost patients



Curtis Peterson, Health Resilience Specialist and Gordon Rasmussen, Client

- Integrated with Primary Care Team
- Care Coordination with Specialists & MH providers

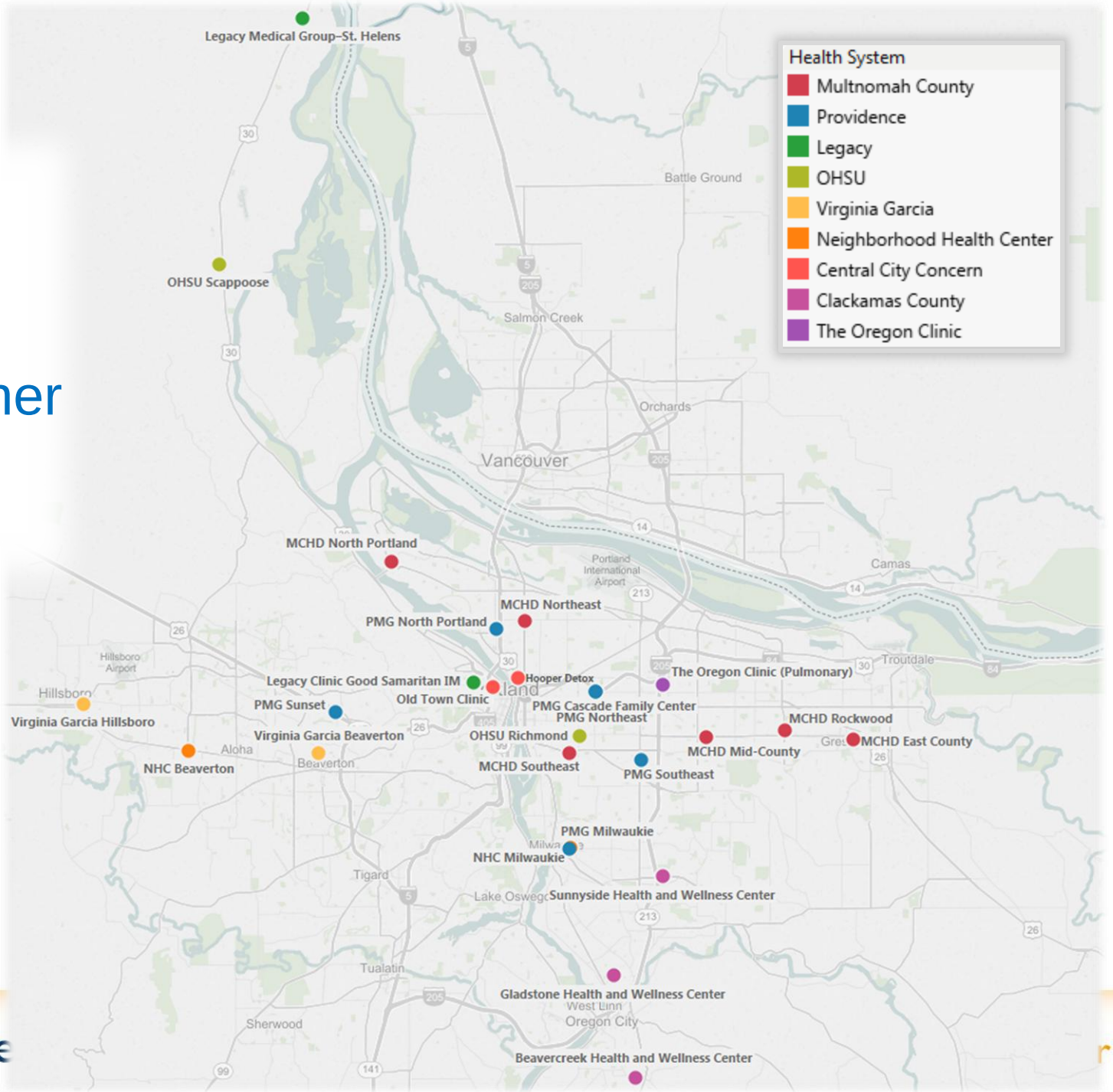


- Basic Needs: food, shelter, safety, ADLs
- Supportive relationships
- Trauma recovery
- Hope & Purpose

- Health risk behaviors
- Cognitive / coping skills
- Health literacy

Health Resilience Program Clinic Partner Locations

(June 2015)



Care

The “ HRP Team”

1 Manager + 3 Supervisors
1 Program & Data Specialist
2 Triage Coordinators
1 Outreach Respiratory Therapist
1 Housing Case Maager
30 Health Resilience Specialists
6 Peer Support Specialists & 2 Recovery Mentors (subcontracted to CBOs)
26 Clinics
5 counties

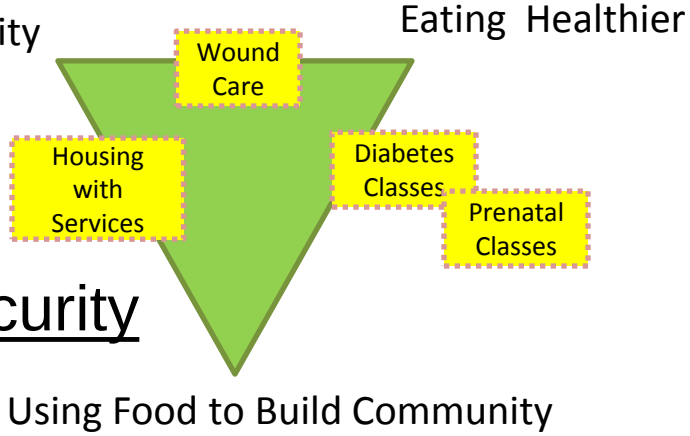
Addressing the Social Determinants of Health:
CareOregon's Community Health Innovation Programs

Reducing food insecurity, social isolation and homelessness by addressing barriers to fundamental needs.

Four programs:

- Food Rx
- Give2Get
- Housing with Services
- CareOregon Goes Mobile

Food Rx



Eating Healthier & Reducing Food Insecurity

Exploring the curative potential of food at Central City Concern's wound care clinic:

- *"There are patients in our wound clinic whose wounds are not healing because they don't get enough protein and nutrients in their diet"* …provider at CCC
- Providers will ID patients with clinical signs of malnutrition and prescribe limited doses of nutrition (3-6 weeks)
- Partnership with Farm to Fit: locally sourced, high protein, prepared meals delivered to patient homes or to the clinic

Eating Healthier & Building Community:

Exploring the preventive potential of food by pairing access to food with nutrition education

- Partnering with Oregon Food Bank who teaches "Cooking Matters" Classes, and adding a food access solution Grocery Getter Organic for participants with certain conditions (ie diabetes or pregnancy)
- Partnership with Women's Healthcare Associates to add a nutrition during pregnancy series to their Centering in Pregnancy Group Visit model

Give2Get™

Community.Connection.Exchange.

The Members of Give2Get planned a food drive for Park Tower's empty food pantry. On average 20 people a week (from Only Park Tower) visit this food pantry to address their food insecurity.

- A program that brings community members together to help each other
- Managed by CareOregon program manager (MSW) and two PSU social work interns
- Relies on peer-to-peer giving exchanges and member-driven socialization events

Mel & Sarah at Grocery Outlet

391 lbs of food

Darlene gave her old wheelchair to Give2Get. While Mary waits for her new wheelchair, she gets to use the wheelchair donated by Darlene.

The Members of Give2Get used 33 pounds of dried beans to make 26 gallons of chili for our chili supper at the Weinberg Center. The leftovers were distributed to various buildings for those unable to make the event.

HOUSING WITH SERVICES MODEL

Federal Medicaid Waiver

Oregon DHS and Health Authority

Funds for program development

Insurance payers contract for services

Portland State Univ. Program evaluation

Resident Advisory Council Project Support

Culturally specific program services

Housing Stabilization

Home Care

Mental Health

Health Care

Substance Abuse Treatment

Case Management

Consortium

Resident Empowerment and Involvement

Housing with Services

- 650+ CareOregon members-50% are duals
- CareOregon has made a capital investment in the LLC as well as devoting 1.5 FTE health navigators (1 RN, 0.5 Coordinator), leadership support, and is bringing other internal programs into the building
  - Assisted over 350 residents with care coordination, health screening, and referral to critical services
  - Providing post-ED and post-hospital care management
  - Lifeworks and Cascadia are providing on-site mental health services
  - On-site urgent care clinic

CareOregon™

Collective Impact: Housing with Services meets Food Rx and Give2Get

Community.Connection.Exchange.

Reducing Food Insecurity & Building Community:

Food Rx developed a partnership with Urban Gleaners, HWS, and G2G volunteers that resulted in moving close to 500 lbs of food (including protein and produce) to residents who really needed it. G2G volunteers repackaged the prepared food, and helped distribute produce and Dave's Killer Bread to 10 HWS buildings.

Total Cost to CO = $68 in packaging materials.

“CareOregon Goes Mobile” Initiative

Portland Rescue Mission and City Team Ministries

Thank You!

Questions?

Email: ramsayr@careoregon.org

CareOregon™
better together

www.careoregon.org | facebook.com/careoregon | twitter.com/careoregon