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

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Benton County Health Services

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

Environmental Health
- Inspections/codes
- Preparedness

Developmental Diversity
- Individual Supports
- Case Management

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

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
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
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
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
How we do the work...

Health Navigator Continuum
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
Where Clinical Navigators work

11.0 FTE

1- Supervisor

6- Coverage for each of the CHC clinics

4- Samaritan Health Services clinics
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

*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
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

2016-2017 school year
5,215 total touches/Care STEPs

2017-2018 school year (July-November)
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)
Woven Net of Client Care

- Clinic
  - Clinical Navigators
  - CAWEM and CWX
  - Establish Care at CHC
  - Soy Sano
  - DD Services
  - Interpretation Services
  - Oral Health Navigator
  - Dental Services

- Oregon MothersCare
  - Housing Services
  - Oregon Health Plan
  - Legal Services
  - Financial Assistance

- Maternity Case Management
  - WIC
  - Transportation Services
  - McKinney Vento

- School Navigator
  - School

- OHP/Resource
  - OHP Navigators
  - Client
  - Food Bank
  - Reproductive Health Screening
  - Mental Health Services
  - Energy Assistance

Health Navigation Web
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
Contributions to Success

• Leadership support
• Delivery System Transformation opportunities
• Strong community partnerships
• Community need
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.
INHALE,
EXHALE,
Y
REPITA
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.
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
Freedom  Support  Encouragement
Our Catalyst Project

See and Experience

Question and Reframe

Dimension and Diagram
Catalyst Process, Continued

Imagine and Model

Pitch and Commit

Test and Shape
‘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.’
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
**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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**Education and Learning**
- **How do you learn best?**
- **What is the highest level of school that you have finished?**

**Financial Resource Strain**
- **How hard is it for you to pay for the very basics like food, housing, heating, medical care, and medications?**

**Housing**
- **In the last month, have you slept outside, in a shelter, or in a place not meant for sleeping?**
- **In the last month, have you had concerns about the conditions and quality of your housing?**
- **In the last 12 months, how many times have you moved from one home to another?**
- **Number of positive responses to housing questions**

**Food Security**
- **(We) worried whether (my/our) food would run out before (we) got money to buy more in the last 12 months?**
- **The food that (we) bought just didn’t last, and (we) didn’t have money to get more in the last 12 months?**
- **(We) couldn’t afford to eat balanced meals in the last 12 months?**
- **Number of positive responses to food security questions**

**Exposure to Violence**
- **Have you ever been physically or emotionally hurt or threatened by a spouse/partner or someone else you know?**

**Physical Activity**
- **On average, how many days per week do you engage in moderate to strenuous exercise? (0-7)**
- **On average, how many minutes do you engage in exercise at this level?**
- **Weekly Physical Activity**

**Social Connections and Social Isolation**
- **Are you married or living together with someone in a partnership?**
- **In a typical week, how often do you talk with family, friends, or neighbors by phone or video chat (e.g., Skype, Facetime)?**
- **In a typical week, how often do you get together with family, friends, or neighbors?**
- **In a typical week, how often do you use email, text messaging, or internet (e.g., Facebook) to communicate with family, friends, or how often do you attend church or religious services?**
- **How often do you attend meetings of the clubs or organizations you belong to?**
- **Social Isolation Score**
- **How often do you feel lonely or isolated from those around you?**
- **Do you have someone you could call if you needed help?**

**Stress**
- **During the past month, how much stress would you say you experienced?**

**Help Desired**
- **Would you like assistance with any of the above items?**

[Image of PRAPARE* tool flowsheets]

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*Community Health Centers of Benton & Linn Counties*
Current Workflow

After 1-2 Weeks

- Patient has an appointment and checks in at the clinic.
- Patient leaves and attempts to connect with resource.
  - Health Navigator calls the patient to inquire about how the referral went.
- Patient is given the PRAPARE tool to fill out.
- Provider reviews the half sheet before seeing the client.
- Health Navigator asks about other concerns, refers to other services as needed.
- PRAPARE tool is condensed onto a half sheet containing referrals made.
- Medical Assistant rooms the client as usual.
- Patient meets with a health navigator to review PRAPARE Tool.
- The Health Navigator makes a meaningful referral to local social services.
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

Leading barriers to screening patients for SDH

- Staffing/workflow implementation 72%
- EMR / Technical implementation 14%
- Lack of leadership support 4%
- Other 10%

Additional barriers:
- 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
The Social Determinants of Health Academy

Culture
- Resiliency
- Management

Operations
- Staffing
- Systems

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
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:

- Fuel: 51%
- Food: 49%
- Housing: 43%

65% were Food Insecure - 47 people

54% were lonely or isolated - 3 people responded Always

24% experienced a lot of stress
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
From the Field
‘We have some struggles’
‘Especially if I don’t get my deer...’
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?
____________________________________________________
____________________________________________________
____________________________________________________
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Thank You