

2024 Forum on Rural Population Health & Health Equity



Addressing SDOH by Providing Integrated Patient Navigation Services

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2024 Forum on Rural Population Health & Health Equity

- Audio has been muted for all participants upon entry
- Moderators will assist with Q+A at the end of the presentation
- Presentation slides will be posted at ohsu.edu/orhforum
- Sessions will be recorded and available to attendees
- Please take the session surveys!

AHCG

**ADDRESSING SOCIAL DETERMINANTS OF HEALTH
BY PROVIDING INTEGRATED PATIENT NAVIGATION**

Patient Centered Care

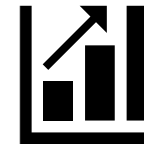


THE CONCEPT

Resolutely and effectively address the inequalities in our diverse community to minimize variations in health services delivered.



BUSINESS MODEL OF CASE MANAGEMENT



Service Line Integration

- Health Screening Support
- Remove Barriers for patients impacted by the Social Determinants of Health - SDOH (Insurance, Housing, Language/Culture, Transportation, and Food Insecurity)
- Referrals for Further Care

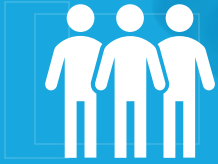
Discharge Planning

- Transition of Care (Medications, Durable Medical Equipment (DME), SDOH)
- Resources and Referrals
- Post-Discharge Follow-up
- Address Social Issues/Reduce Readmissions and LOS

Financial Support

- Cost Avoidance
- Care Enhancement
- Certification to enhance possibility of payment
- Grants
- Payment Incentives

PATIENT NAVIGATION GOALS



Improved Population Health



Preventative Care and Health Screenings



Address Barriers and SDOH



Increase Referrals and Panels



Insurance Assistance

Success

TEAM APPROACH

Patient Navigation Overview

The Concept of Working to Highest Level of Licensure:

CHW and QMHA staff collaborate with clinicians, nurses, counselors, social workers and community partners to provide individual navigation, trust/relationship building that leads to improved engagement, identification of barriers and improved self-management

Inpatient Care Management

Case Management Nurses

- Physical Needs Assessments
- MCG – Patient Class (IP/OBS)
- Skilled Nursing Facility Placement
- VHS Coordination
- Wound Care
- Outpatient Infusion
- Durable Medical Equipment Needs

IP & OP Care Management

Social Workers/Counselors/QMHA

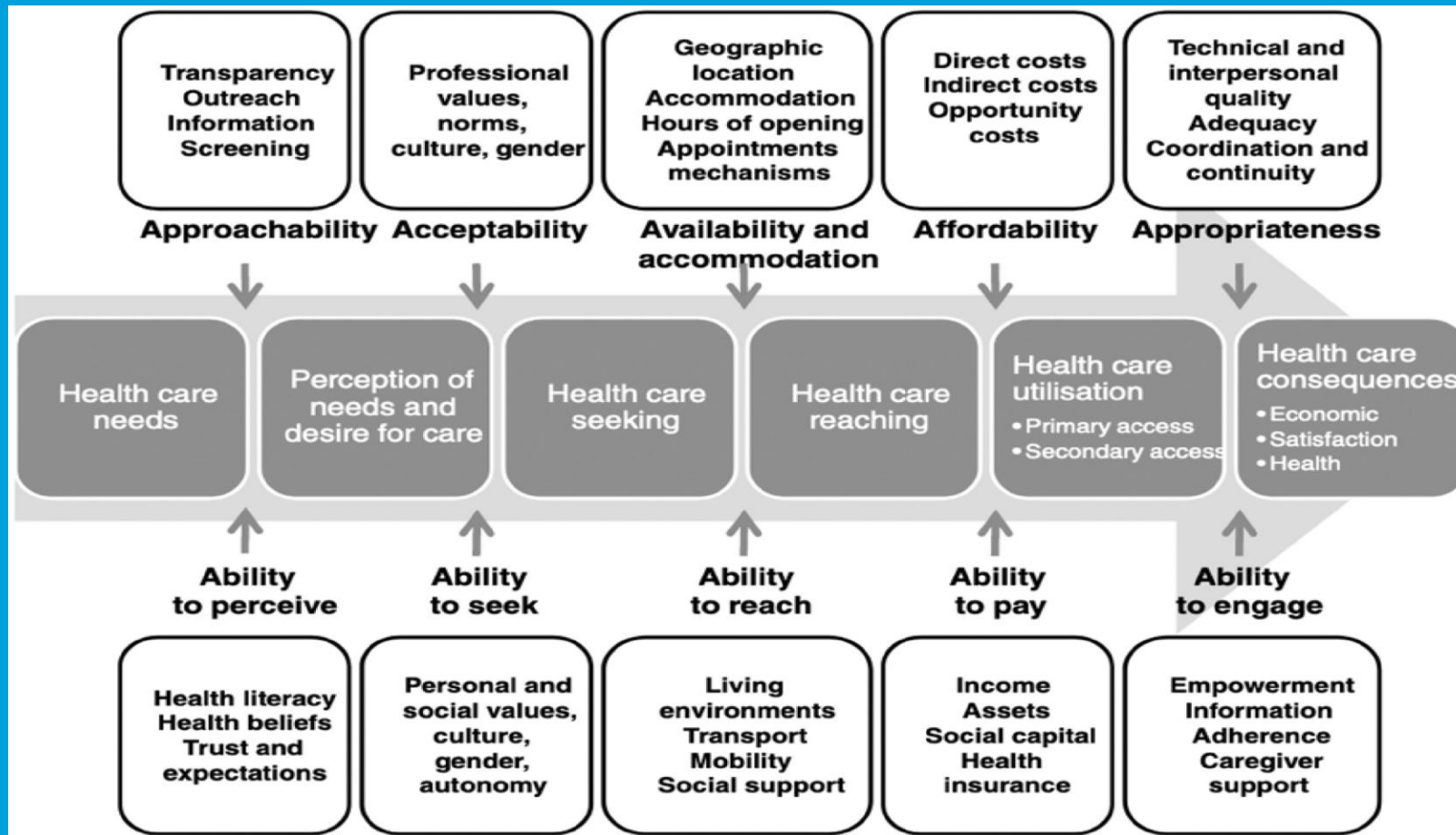
- BH/Social Needs Assessments
- Addiction Services
- Housing Support
- Food Insecurity
- Rehab Assessment
- Connect with Community Resources
- Transportation

Outpatient Chronic Care Mgmt

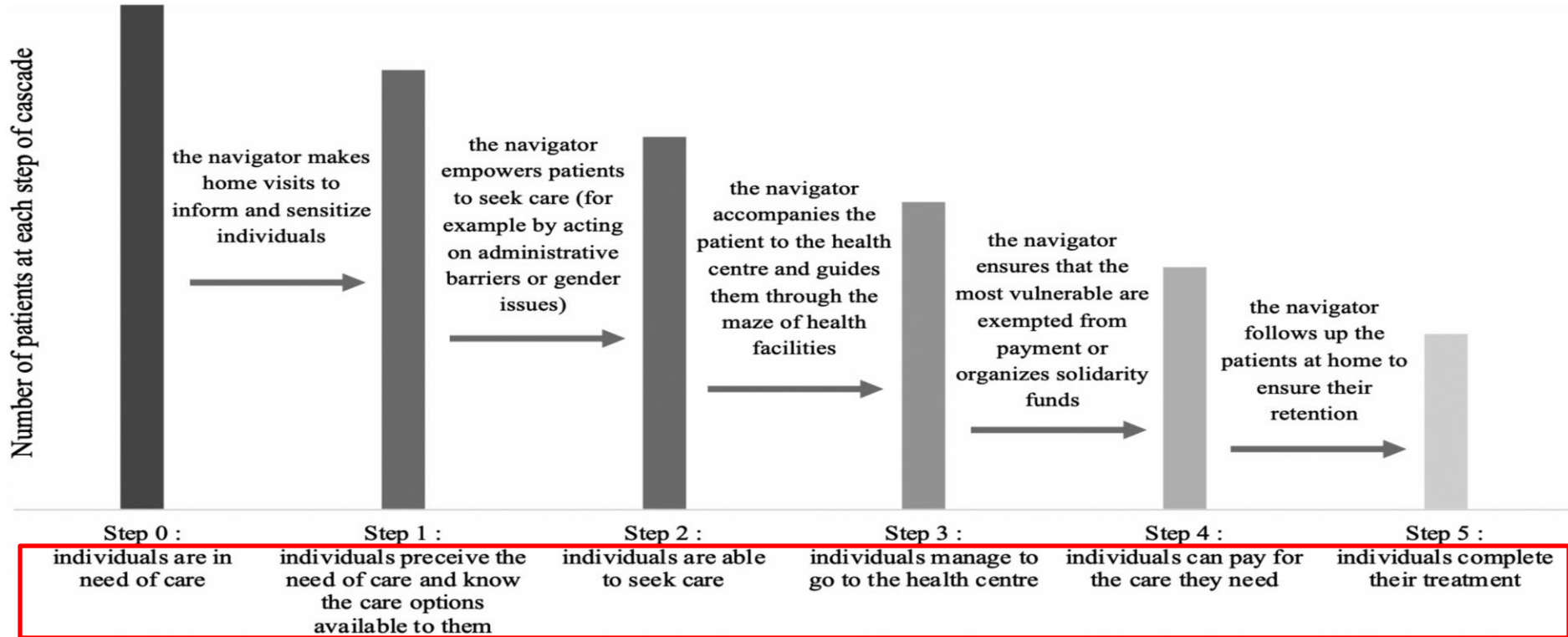
Chronic Case Management Nurses

- Manage Chronic Illness Needs
- Referral Protocol:** Pulmonary Rehab, VHS; Sleep Medicine; Cardiology; Cardiac Rehab; Ophthalmology; Podiatry; Diabetes Education; Nutrition; Medical Exercise; Early Intervention; Reach; BH Services; Speech Therapy and Physical Therapy
- Automatic and PCP Referred Enrollment
- Follow High Needs Patients 3+ ED Visits in 6 months

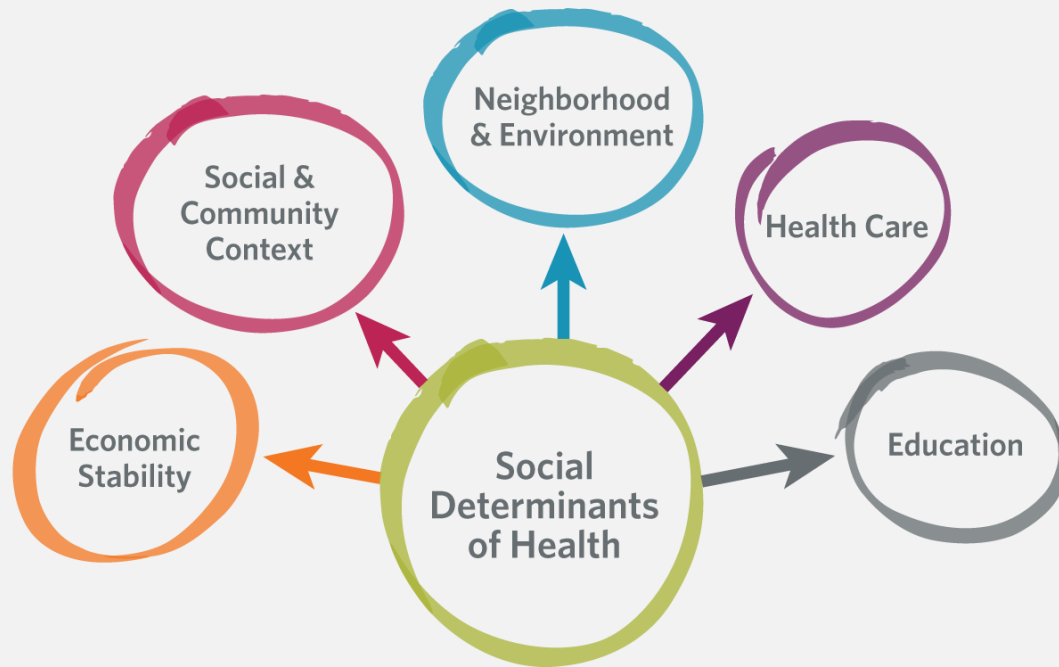
A CONCEPTUAL FRAMEWORK OF ACCESS TO HEALTHCARE



CARE CASCADE AND CARE PATH



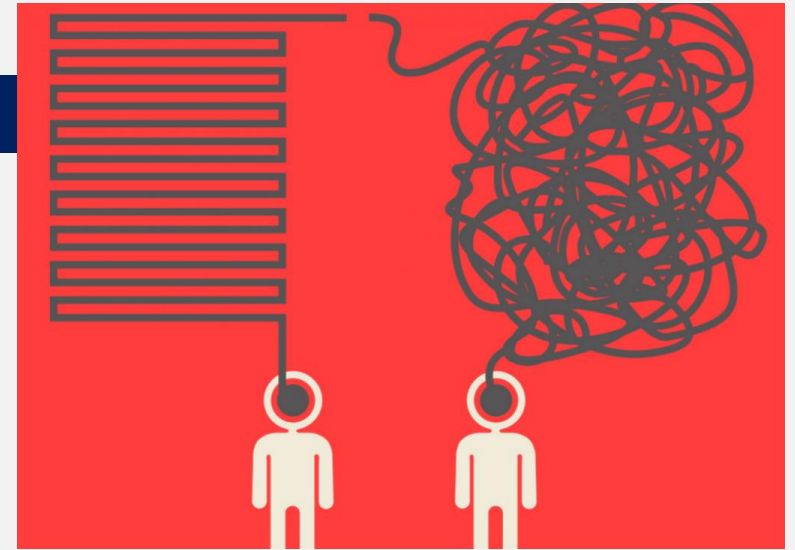
SOCIAL DETERMINANTS OF HEALTH



- The Social Determinants of Health (SDoH) are economic and social conditions in which people are born, grow, live, work and age. These conditions are shaped by the distribution of wealth, power, and resources at global, national and local levels. Cara James, Ph.D., and Director of the Office of Minority Health at the Centers for Medicare & Medicaid Services (CMS), estimates that the **SDoH equals 80% of an individual's ability to access and maintain health**. The ZIP code in which an individual resides, access to fresh foods, transportation, and ability to pay for prescription medications are some examples of SDoH and are linked to health literacy.

HEALTH LITERACY IS KEY

Why is Health Literacy Important?



Only 12% of Americans have proficient health literacy. This means that nearly nine out of 10 adults likely lack the skills required to manage their health and prevent disease. Health literacy is essential for a healthy population and even more critical during times of national emergencies such as the COVID-19 pandemic.


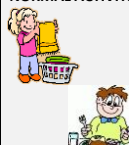


Based on its impacts, including, medical errors, increased rates of illness and disability, loss of wages, and compromised public health, **low health literacy is estimated to cost the U.S. economy approximately \$236 billion every year**; this data does not include the financial devastation caused by the current pandemic.

ZONE TOOLS





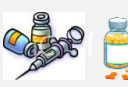

COPD Zone Tool - How do I feel today?

Which Zone are you in? ----->>>	GREEN ZONE  Well-Controlled	YELLOW ZONE  Call Doctor or Nurse Today	RED ZONE  See Doctor Today, Go to ER, or Call 911
COUGH 	Cough is Normal	Cough is Worse Than Normal Change in Mucus: • More than normal • Looks yellow, green, or gray	Cough is Not Going Away
MEDICINE 	Normal Dose is Working	Using More Medicine Than Normal	Medicine is Not Working
BREATHING 	Breathing is Normal	Trouble Breathing While... • Walking • Talking • Eating • Bathing • Dressing	Having Trouble Breathing at Rest
OTHER		Feeling... • Tired • Restless • Confused • Sleepy <u>Fever:</u> 100 -101.5	Chest Pain / Pressure • Won't go Away Lips / Nails • Blue or Gray <u>Fever:</u> Over 101.5








DEPRESSION Zone Tool - How do I feel today?

Which Zone are you in? ----->>>	GREEN ZONE  Well-Controlled	YELLOW ZONE  Call Doctor or Nurse Today	RED ZONE  See Doctor Today, Go to ER, or Call 911
NORMAL ACTIVITIES 	You Can Concentrate You Feel Good About: • Getting up • Facing the day • Socializing	You Feel Sad, Tired, or Nervous about doing Normal Activities You Do Not Want To: • Get up • Face the day • Socialize	You Would Rather: • Stay in Bed • Not Socialize • Not Eat Can't Concentrate You Do Not Feel Anything
SLEEP 	No Change in Sleeping Patterns	Sleeping Patterns Have Changed: • Sleep More or Less • Have Trouble Falling or Staying Asleep • Stay Awake and Worry	Worry Most of the Night Sleep A Lot During the Day and Keep Room Dark
MEDICATION 	Taking Medication and it Works for You	Taking Less Than Your Doctor Prescribed Because: • It is more than you need • You do not like the side effects • You worry about being addicted to it	You Do Not Take Your Medication Because: • It is not helping • You do not need it
THINK ABOUT HURTING YOURSELF 	Feel Hopeful No Thoughts of Hurting Yourself	Sometimes Think of Hurting Yourself, but Do Not do it Because: • You do not believe in Suicide • You are Afraid to Die	Feel Like Life is Not Worth Living You Have a Plan for Killing Yourself

DIABETES Zone Tool - How do I feel today?

Which Zone are you in? ----->>>	GREEN ZONE  Well-Controlled	YELLOW ZONE  Call Your Doctor or Nurse Today	RED ZONE  See Doctor Today, Go to ER, or Call 911
BLOOD SUGAR 	Fasting Blood Sugars • 70 – 150 Average Blood Sugars • Under 180	Fasting Blood Sugars • Regularly in the 200's Average Blood Sugars • Over 250	Blood Sugars • Less than 70 • Over 350 Feel... • Sweaty • Shaky • Light-Headed • Confused
MISSED DOSES OF MEDICINE 	No Missed Doses	Missed at least 1 Dose in the Last 24 Hours <i>because...</i> • Out of Medicine • Not Sure How to Take Medicine • Don't Feel Like You Need It	Have Not Taken Medicine and: • Need to Pee More • Feel More Thirsty or Hungry Than Usual • Have Less Energy
DAILY FOOT CHECK 	No Sores on Feet	New Sore on Foot	Sore on Foot that is Not Healing after 1-2 Weeks

PNEUMONIA Zone Tool - How do I feel today?

Which Zone are you in? ----->>>	GREEN ZONE  Well-Controlled	YELLOW ZONE  Call Doctor or Nurse Today	RED ZONE  See Doctor Today, Go to ER, or Call 911
COUGH? 	No Cough... or Cough is Normal Mucus coughed up Looks: • Clear • White	Cough • Worse than normal Mucus coughed up Looks: • Yellow • Green • Streaked w/Blood	Cough • Lasting longer than a Normal Cold Chest Pain / Pressure • Won't go away
FEVER? 	No Fever	<u>Fever:</u> 100–101.5	<u>Fever:</u> Over 101.5
ENERGY LEVEL? 	Energy Level is Normal	Too Tired to do <i>most</i> Normal Activities	So Tired you can hardly do <i>any</i> Normal Activities
BREATHING? 	Not Short of Breath Breathing is Normal	Short of breath or cough while... • Walking • Talking • Eating • Bathing • Dressing	Short of Breath at Rest Less Alert

FINANCIAL SUPPORT

Funding the Work

- Cost Avoidance
 - LOS
 - Utilization
- Revenue Enhancement (VBC)
- Referrals
- Community Health Worker Certification (PMPM Incentives)
- Grant Funding at \$350K+ 2024
- Patient Assistance Funds through the AHCG Health Foundation




CCO & ACO

- ✓ Participation in CCO and ACO leads to Incentivized Preventative Care
- ✓ Value Based Contract Payments with Shared Savings
- ✓ Capitation and PMPM Incentives
- ✓ Ensures full Medicare Reimbursement for Services




Our Working Models



Our work at CGHC governs the Columbia Gorge Coordinated Care Organization (CCO) by allocating spending, operating collaborative programs and convening partners for health improvement efforts advised through our two main groups:

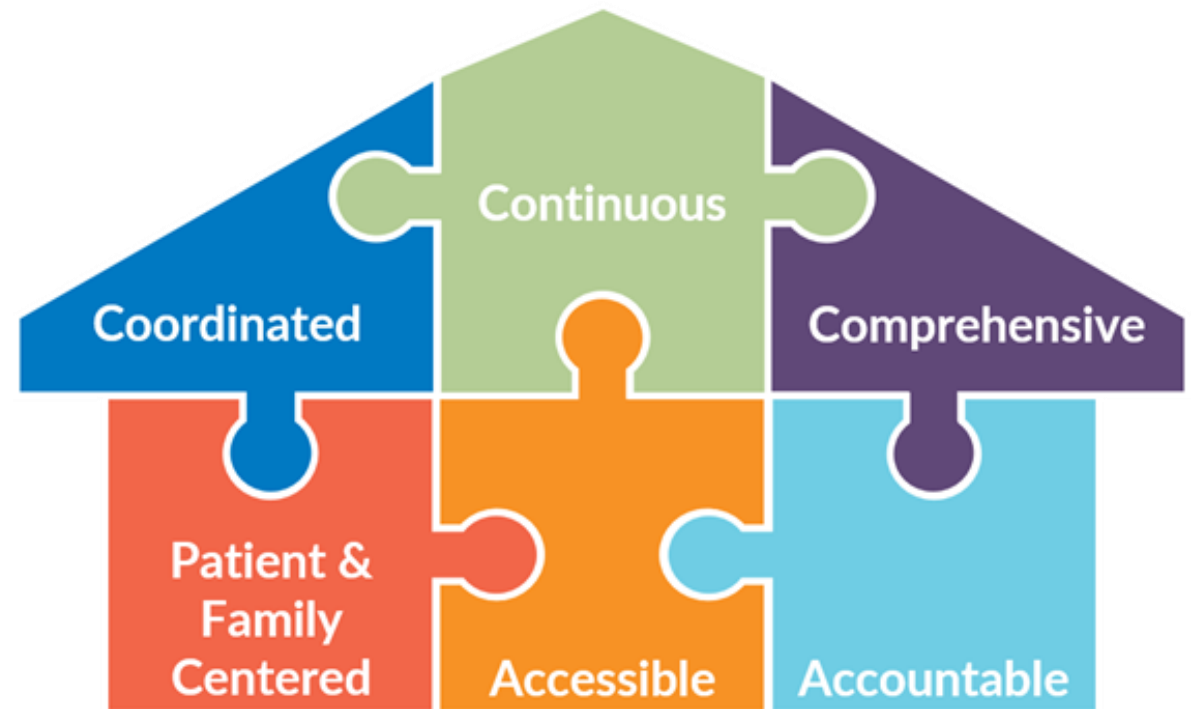
Community Advisory Council (CAC) >50% Consumer Voting Members Stewards of community needs and health improvement plan Champions community priorities.	Clinical Advisory Panel (CAP) Primary and behavioral clinicians Stewards of best clinical practices Clinical standards in community Implementation of clinical priorities
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Two working advisory groups, one mission;
elevate the well-being of everyone living in the Columbia Gorge.

PCPCH STAR 5

*Highest Achievement for
Patient Centered Care*

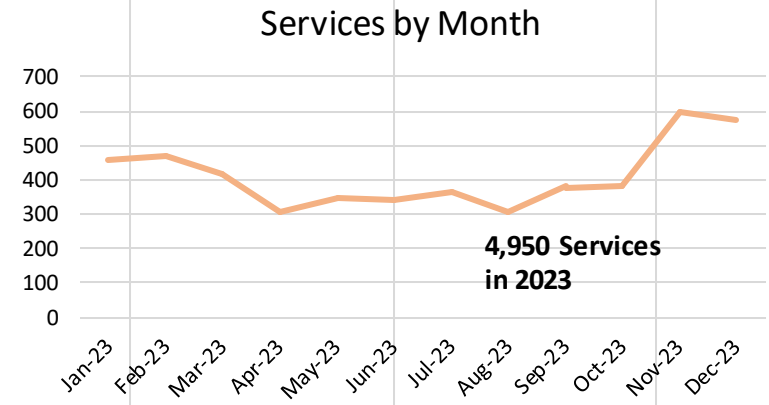
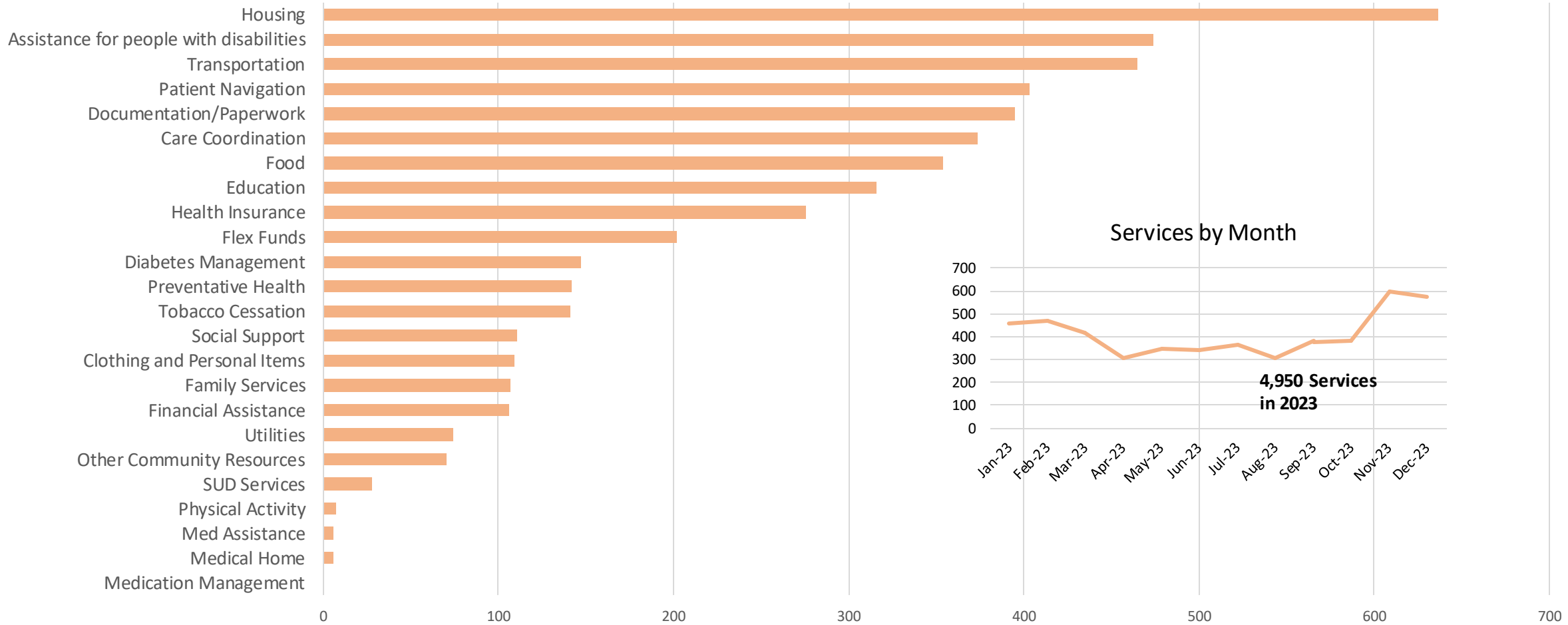


**SOME OF
OUR WINS**



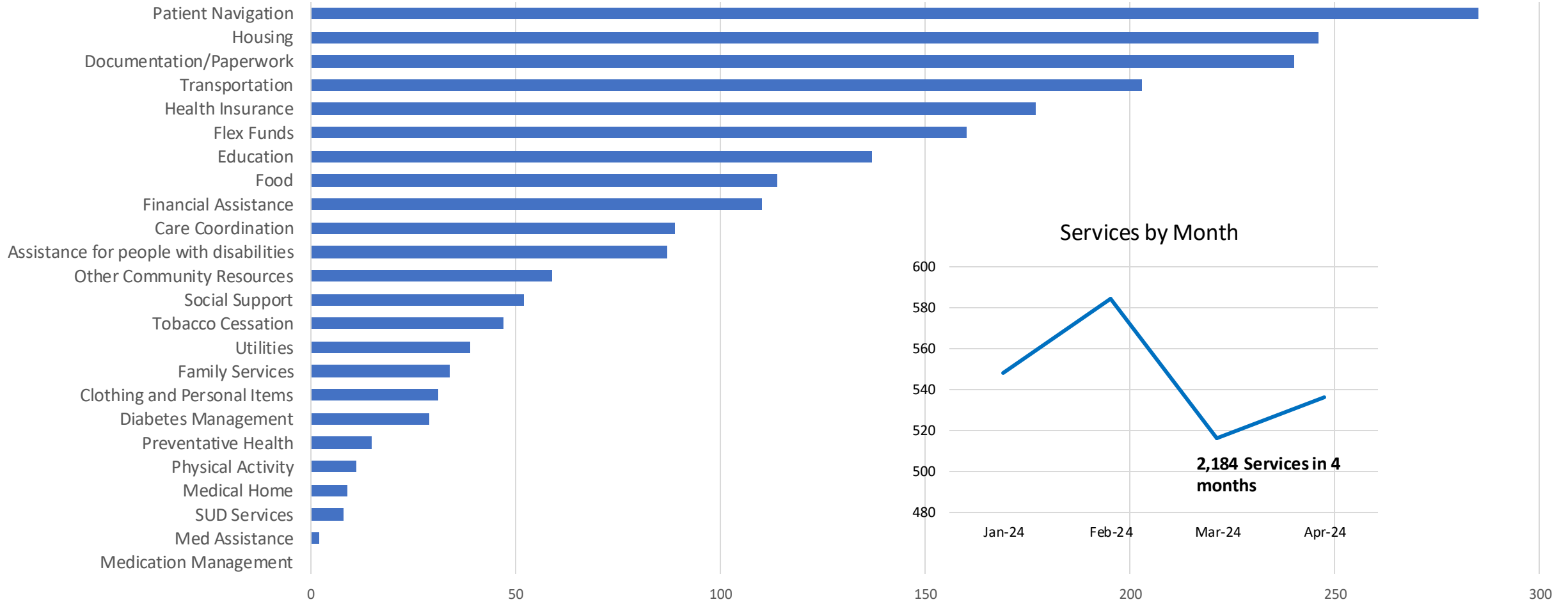
INCREASED OUTREACH AND SUPPORT

Case Management Services Provided Jan 2023 - Dec 2023



INCREASED OUTREACH AND SUPPORT

Case Management Services Provided Jan 2024 - Apr 2024



SOMOS & DIVERSITY, EQUITY AND INCLUSION WORK

Serving Oregon's Migrants Offering Solutions – 2023 National Rural Health Program Award



COMMUNITY PARTNER MEETINGS

- Helping Hands
- Hearts of Gold
- Caption Call
- Aging People & Disabilities
- Adult Protective Services
- Haven
- Bridges to Health
- Mid-Columbia Center for Living
- One Community Health
- County Health Departments
- The Next Door
- LINCARE
- Skilled Nursing



Mt. Adams
Transportation
Services



MEDICAL CLINIC
REGNANCY DIAGNOSIS AND SUPP



- NORCO
- WIC
- Hope Medical
- Meals on Wheels
- St. Vincent de Paul
- Fish Food Bank
- Windy River Gleaners
- Mt Adams Transport
- CAT Transport
- HUD Housing
- Pacific Source Insurance Flex Funds
- Assisted Living
- Hospice



CHALLENGES

- Sustainable and consistent funding
- Staff training and education
- Lack of resources
- Leadership buy-in
- Data that represents avoided healthcare costs.

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Thank you.

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Thank you to our partners!

