THE HEALTH RESILIENCE PROGRAM™:
CareOregon, Health Share of Oregon, and Community Clinics Partner to Improve Care for High Risk/High Cost Patients

Laurie Lockert, MS, LPC: Health Resilience Program™ Manager, CareOregon
“Transforming Health Care”

• Key CCO Strategy: focus on “high utilizers”
• 2012: Health Share of Oregon partners receive CMMI Funding to develop regional system of care for high needs members.
  – Multi Organizational Effort
  – Multiple Interventions in ED, Hospital, Primary Care, 911 system
• Key strategy for ROI: enhancing primary care ability to support high needs members
The Goal

• Reduce unnecessary utilization and improve health status & healthcare experience

• Case Timeline: 3-9months

• Employing trauma informed principles:
  – Transparency
  – Trust
  – Time
  – Person centered
  – Voluntary
Specific Program Criteria

- Identify clients through Ins Claims & Encounter data & Clinic staff
- Adults who are receiving care at participating Clinic
- 6+ NON OB ED visits in 12 months
- 1 NON OB IP stay in 12 months
- Modifiable behaviors
- Willingness to change
- HSO insurance
Health Resilience Specialists™ are paired with primary health homes and specialty practices to provide individualized ‘high touch’ and ‘trauma-informed’ support to patients with exceptional utilization. Primary emphasis is to help mitigate social determinants of health.

Staff are supported by clinically licensed supervisors who provide daily and weekly guidance, mentoring and clinical supervision.
The Health Resilience Program™

Good Sam: Curtis Peterson paired with RN, social worker, and pharmacist
Emanuel: Beatriz Navarro paired with RN, social worker, and pharmacist
PMG Northeast: Erika Crall
OHSU Richmond: Lisa Pearlstein Laurie Ricken paired with social worker, pharmacist, and high risk panel manager
PMG SE & Milwaukie: Amy Baker paired with social worker
MCHD North Portland: Emily Kelley
MCHD Northeast: Amy Vance
MCHD MidCounty: Lisa Achilles Mark Sexton paired with pharmacist

CareOregon Leadership and Support:
Director – Rebecca Ramsay
Manager – Laurie Lockert
Supervisors – Kevin Mahon & Lolita Markovich
Triage & HP Liaison – Margaret Wheelhouse
Data, Reporting, Evaluation & PopIntel – Debra Read & Rachel Hammer
Program Admin – Debbie Haren
Adding a Team Member who...

- Embedded with Medical Home Team: Doctor, RN, LCSW, behaviorist, Pharmacist, Care Manager Resource Specialist, psychologist, etc.
- 50%+ of time is spent in the community
- Documents in Clinic EHR
- Access to CareOregon Insurance Claims/ Encounter data, Pharmacy Dept, etc.
What Makes the Program Successful?

• Employed by CareOregon, but embedded in clinic-based teams
• Standardized workflows, “PopIntel Registry”
• Supportive Learning Environment
  – Weekly: Multi-disciplinary ‘Huddles’; Team Mtg
• Active Clinical Supervision
  – Phone In Case Review; Individual Case Supervision
• Competency Based Trainings
• ‘Trauma Informed Care’ Culture
• Medical Home “Champion”
HRS’s ‘Mission Control’

- **Triage Coordinator**: “Real time” Case Finding in daily ED and IP from all Oregon hospital systems for HSO members; fielding insurance benefit questions; connecting staff to Benefit Specialists; outreach via phone to members not using their PCP
Mission Control, Cont.

- Program and Data Coordinator
- Clinical Supervisors
- Senior Evaluation Assoc
- Program Manager
- Program Director

Infrastructure Critical
Health Resilience Specialist™ Skillset

- Mental health/addictions training
- Extensive outreach experience with the Medicaid population
- Understanding of trauma dynamics
- Ability to work across cultures
- Ability to think individually & systemically
- Excellent communication & ‘assessment’ skills
- Ability to build trust, set professional boundaries with compassion
Health Resilience™ Interventions

Address the psychosocial to improve the medical

• A Trauma Informed Care approach
• Assistance in navigating health care system
• Care/system coordination
• Health literacy education
• Assistance with complex problem solving related to living in poverty with multiple health issues
• Motivational Interviewing
• Role modeling social skills
• Listening
Health Resilience Program™

222 Clients
Engaged AT LEAST 1x on or Before June 30th, 2013

Preliminary Findings
Please DO NOT circulate without Permission

NonOB IP admits - PMPY

PMPY Inpt Rate
Pre: 2.2
Post: 1.2
Health Resilience Program™

222 Clients
Engaged AT LEAST 1x on or Before June 30th, 2013

PMPY ED Rate
Pre: 9.6
Post: 6.23

Preliminary Findings
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Provider and Client Perspectives

“(The program) has been invaluable, because there are aspects of our patients’ lives that we don’t know about. And that can be anything from DV going on, which helps inform the way I steer my counseling of a patient around contraceptive issue...to how to pace changes or let her have a little more time while she consolidates her social structures”

“It helps to have someone present during and after appointments to improve the retention of information for the patient. The HRS can reframe it for the patient following the visit and check in around understanding of what the plan is”

And from the client:

“I haven’t been back in the hospital since I started working with my outreach worker. I was in the hospital like 8 or 9 times before.”

“I’m managing my conditions a lot better now, to where I don’t have to go to the emergency department anymore unless its life threatening.”

“It was just me going to my doctor, and my doctor telling me things I really couldn’t understand. Now with the outreach worker, she helps me to understand all those doctor terms.”
Health Resilience Specialist

Mayela Torres
Based at Virginia Garcia Memorial Health Center (Hillsboro)
Multi System Approach

Hospital

Client

Primary Care
Clinic/Specialty Care

Community
- Outpatient MH
- Natural Supports
  - Spiritual
  - Rehab Services
Interventions

- Advocacy
- Motivational Interviewing
- Individual Resource Building
- Collaborate with Primary Care
- Health Literacy
- Bolster Healthy Community Supports
- Facilitate Multi-Disciplinary Care Planning
Individual

- Provide outreach to clients in the community, clinic, home and hospital.
- Assist in building skills around preventative care (i.e. setting up regular appointments, calling medical advice line, med adherence, self care, forming health questions)
- Familiarize the client with all their primary care clinic’s services which is specific to their clinic. (acupuncture, nutritional classes, wellness center, group classes, etc)
- Motivational Interviewing to cultivate change in the area desired for the client.

Community

- Assess current status and tailor resource information to client’s individual needs.
- Work with mental health agency programs to coordinate cohesive care with PCP for clients with complex mental and physical health.
- Encourage development of relationships with family and/or friends.
- Address social determinants of health and introduce methods to connect them with long term interventions.

Medical System

- Work closely with clients’ primary care provider team to address and problem solve around services for the client.
- Work alongside the client to follow through with PCP orders and empower them in their own health.
- Attend medical/specialty appointments to facilitate better communication and understanding. Side by side coordination with client.
- Provide patient rich information to all providers involved in clients' care.