Improving Health and Reducing Disparities

ORPRN Studies and Projects in 2019
Presentation of ORPRN projects

• Seven projects in one hour
• Presentations will follow a similar format
  – What critical question does this project answer?
  – How does this study improve health outcomes or health equity?
• Small amount of room for Q&A
  – Track down presenters at the snack table
Becoming an ORPRN project

- Ability to improve health outcomes or address health disparities found in primary care
- Emphasis on care for all Oregonians, especially rural Oregonians

Strategies
- Community partners
- Coaching
- Education
- Research
Multi-PBRN Research

• Multi-network consortium with established communication, contracting, governance, data management.

• Project results are broadly generalizable to primary care in North America.

• Diverse stakeholders support planning.

• Large sample size and diverse study design
  – Pragmatic clinical trial
  – Comparative effectiveness
  – Implementation research
The Meta-LARC
Advance Care Planning (ACP) Trial

Patient-Centered Outcomes Research Institute® (PCORI®) Award (PLC-1609-36277).

Project Dates: 2017-2023
Principal Investigator: Annette Totten, PhD
Project Manager: LeAnn Michaels
Engagement Manager: Angela Combe, MS
Is a team approach to ACP in primary care effective?

Study compares team-based to clinician-focused advance care planning for patients with serious, life-limiting illnesses.
How will ACP improve health equity for Oregonians?

Why Advance Care Planning is Important

- Reduced Depression
- Reduced Anxiety
- Improved Quality of Life

The place for this to begin is at the kitchen table—not in the intensive care unit.

--The Conversation Project
Meta-LARC ACP PBRNs/Partners

7 Practice-based Research Networks
42 Primary Care Practices (6 per PBRN)
Patient Family Advisors (PFA)

Susan Lowe, ORPRN
Study Design

• Cluster randomized trial
  – Practices are assigned by chance to team-based or clinician-focused model for ACP

• Population
  – Patients with any serious illness or condition (would not be unexpected if they died in the next 2 years)
  – Living in the community (not a nursing home)

• Key outcomes
  – Care that matches what matters most to patient
  – Days at home: not in the hospital or emergency room

• Other outcomes
  – Primary care clinician and team experience
  – Family caregiver experience
Patient and Family Engagement in Research

Project has an Engagement Plan as well as a Research Protocol
Engagement Purpose and goals

Meaningful engagement among diverse partners is a core element of the Meta-LARC ACP project.

- Guide the development of tools to support ACP Adaptation.
- Ensure we answer questions and measure outcomes that matter to patients and their families.
- Assure implementation is successful and potentially replicable in real-life primary care settings.
- Enable patients and families to make informed decisions by making conversations about serious illnesses routine in primary care.
Benefits and Experience

- Commitment
- Integration
- Ongoing interaction
- Focus on why we care about this topic
- Personal experiences
- It's just fun! 😊
Next Steps

Email: MetaLARC_ACP@OHSU.edu
A Community-based Assessment of Skin Care, Allergies, and Eczema (CASCADE)

Funding Agency: National Institute of Arthritis and Musculoskeletal and Skin Diseases
Project Dates: 2018-2023
Principal Investigator: Eric Simpson, MD, MCR
Project Manager: LeAnn Michaels
What critical gap does CASCADE address?

- Atopic dermatitis (AD) causes the most disability of any skin disease globally (Global Disease Burden Project, 2013)
- Skin barrier function plays key role in AD
- Can protecting the skin barrier prevent AD and allergies in a community setting?
CASCADE may improve health outcomes for Oregonians

Food Allergy

Asthma

Adult Eczema
Map of Setting
Partners

• Dermatology
• Public Health
• Medical Informatics and Clinical Epidemiology
• Oregon Clinical & Translational Research Institute
• Data and Safety Monitoring Board
• KAI for Research
Study Design

CASCADE Study Design: Pragmatic, multi-site, randomized community-based trial
- Arm A: Daily use of lipid-rich emollient
- Arm B: No moisturizer unless dry skin occurs

Eligibility Criteria:
- Caretaker aged 18 years or older of infant aged 0-2 months
- Infant not diagnosed with eczema
- Speak, read and write in English / Spanish
- Receive care at Meta-LARC clinic at enrollment

Outcome of interest: Cumulative incidence of atopic dermatitis (AD, eczema) when infant/baby is 24 months old
Early findings – Planning project

The CASCADE planning project was published!

What does it say?

- Among 652 children, estimated AD prevalence = 24% (95% CI, 21–28)
  - Under age 1 = 15%
  - Age 4 to 5 = 38%.
- Comorbid asthma was higher for AD (12%) compared to no AD (4%) \( P < .001 \)
- Non-AD use moisturizers with high water:oil ratios

http://www.jabfm.org/content/32/2/191.abstract
Early findings – R01

Enrollment rate

![Graph showing enrollment rate over time, with increasing numbers of participants from July to March. The blue line represents the target enrolled, and the red line represents the cumulative enrolled.]
## Early findings – Feb 2019

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Oregon</th>
<th>Colorado</th>
<th>Duke</th>
<th>Wisconsin</th>
<th>Totals</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Randomized</strong></td>
<td>67</td>
<td>38</td>
<td>8</td>
<td>26</td>
<td>139</td>
<td>1250</td>
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<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>27 (40.3%)</td>
<td>23 (60.5%)</td>
<td>2 (25.0%)</td>
<td>9 (34.6%)</td>
<td>61 (43.9%)</td>
<td>625</td>
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<tr>
<td>Female</td>
<td>40 (59.7%)</td>
<td>15 (39.5%)</td>
<td>6 (75.0%)</td>
<td>15 (57.7%)</td>
<td>76 (54.7%)</td>
<td>625</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>1 (3.8%)</td>
<td>1 (0.7%)</td>
<td></td>
</tr>
<tr>
<td>Not Answered</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>1 (3.8%)</td>
<td>1 (0.7%)</td>
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</tr>
<tr>
<td><strong>Age (in days)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>31.5 days</td>
<td>20.0 days</td>
<td>23.8 days</td>
<td>25.1 days</td>
<td>26.9 days</td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>33.0 days</td>
<td>14.5 days</td>
<td>23.5 days</td>
<td>22.5 days</td>
<td>30 days</td>
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<tr>
<td>StandardDev</td>
<td>12.1 days</td>
<td>17.0 days</td>
<td>12.9 days</td>
<td>12.4 days</td>
<td>14.4 days</td>
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<tr>
<td>Minimum</td>
<td>1 days</td>
<td>0 days</td>
<td>10 days</td>
<td>3 days</td>
<td>0 days</td>
<td></td>
</tr>
<tr>
<td>Maximum</td>
<td>63 days</td>
<td>61 days</td>
<td>38 days</td>
<td>54 days</td>
<td>63 days</td>
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<tr>
<td><strong>Education [1]</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not finish high school</td>
<td>2 (3%)</td>
<td>1 (2.6%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>3 (2.2%)</td>
<td></td>
</tr>
<tr>
<td>High School degree or GED</td>
<td>15 (22.4%)</td>
<td>8 (21.1%)</td>
<td>1 (12.5%)</td>
<td>2 (7.7%)</td>
<td>26 (18.7%)</td>
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</tr>
<tr>
<td>Some college education</td>
<td>17 (25.4%)</td>
<td>11 (28.9%)</td>
<td>3 (37.5%)</td>
<td>8 (30.8%)</td>
<td>39 (28.1%)</td>
<td></td>
</tr>
<tr>
<td>4-year college degree</td>
<td>23 (34.3%)</td>
<td>12 (31.6%)</td>
<td>2 (25%)</td>
<td>10 (38.5%)</td>
<td>47 (33.8%)</td>
<td></td>
</tr>
<tr>
<td>Professional degree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>beyond college</td>
<td>9 (13.4%)</td>
<td>6 (15.8%)</td>
<td>2 (25%)</td>
<td>4 (15.4%)</td>
<td>21 (15.1%)</td>
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<td>Prefer not to answer</td>
<td>1 (1.5%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>1 (3.8%)</td>
<td>2 (1.4%)</td>
<td></td>
</tr>
<tr>
<td>Not Answered</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>1 (3.8%)</td>
<td>1 (0.7%)</td>
<td></td>
</tr>
</tbody>
</table>
Next Steps

• Enroll newborns through October 2020
• Primary outcomes through December 2022
• Work with Family Medicine and Pediatric practices to disseminate

www.CASCADEEstudy.org
CASCADEEstudy@ohsu.edu
LeAnn Michaels, michaell@ohsu.edu
ORPRN Research

• Emphasis on addressing health disparities occurring in Oregon, especially rural
• Standardized facilitation approach for implementation, quality improvement, data collection, study monitoring
• Benefits from strong local collaborators
  – Project design
  – Data analytic plan
  – Subject matter experts
RAVE: The Rural Adolescent Vaccine Enterprise

Funding Agency: American Cancer Society (Award #RSG CPPB - 131717)
Project Dates: 2018 – 2023
Principal Investigators: Lyle (LJ) Fagnan & Patricia (Patty) Carney
Project Manager: Caitlin Dickinson

IRB oversight by OHSU (#18753)
ClinicalTrials.gov PRS, ID#: NCT03604393
What critical question does RAVE answer?

HPV is linked to MANY cancers. There is a vaccine that can prevent the spread of HPV infection, yet vaccination rates fall far short of desired targets. RAVE will shed new light on how communities and primary care practices can improve immunization rates.
How will RAVE improve health equity for Oregonians?

Share that are HPV Up-to-Date (UTD), 2017

<table>
<thead>
<tr>
<th>Total</th>
<th>Poverty Status</th>
<th>Urban/ Rural Status</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>48.6%</td>
<td></td>
<td></td>
<td>53.1%</td>
</tr>
<tr>
<td>53.7%</td>
<td>46.7%</td>
<td>54.4%</td>
<td>44.3%</td>
</tr>
</tbody>
</table>

NOTE: Among adolescents ages 13-17. HPV UTD includes those with ≥3 doses, and those with 2 doses when the first HPV Vaccine dose was initiated before age 15 years and time between the first and the second dose was at least 5 months minus 4 days.

2018 Oregon Adolescent Age 13-17 HPV UTD Rates
# Partners

<table>
<thead>
<tr>
<th>Partner</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Patricia Carney, OHSU</td>
<td>Oversee qualitative and practice-level data; lead exploratory aim (3), supporting practices and community partners in designing and implementing evidence-based intervention</td>
</tr>
<tr>
<td>Dr. Brigit Hatch, OHSU</td>
<td>Lead implementation aim (2)</td>
</tr>
<tr>
<td>Dr. Miguel Marino &amp; Mr. Steele Valenzuela, OHSU</td>
<td>Design and direct statistical analysis</td>
</tr>
<tr>
<td>Dr. Paul Darden, OU Health Science Center</td>
<td>EXPERT: Pediatrics, HPV and other childhood immunizations, and practice-based research</td>
</tr>
<tr>
<td>Oregon Immunization Program, OHA</td>
<td>Link to the Oregon AFIX program; develop relationships with clinics and health systems; implement effective immunization policies</td>
</tr>
<tr>
<td>Jenica Palmer, American Cancer Society</td>
<td>Link to Oregon HPV Summit and other programs in state working on HPV activities; provide local recognition</td>
</tr>
</tbody>
</table>
Study Design

A rigorous study design to test novel interventions for increasing HPV vaccination completion in both males and females aged 11-17 years.

Published Protocol Paper

Early Findings, Aim 1

• Higher performing clinics:
  – Standardized workflows
  – Had vaccine protocols
  – Provided immunizations at every visit
  – Engaged in population outreach strategies
  – Had a vaccine champion
  – Engaged in clear communication with patients

• Lots of missed opportunities to address
  – Unreliable EHR data
  – No 2nd dose recall
Map of Setting, Aim 2
Next Steps

• Finalize Aim 1 analyses & publish findings
• Launch Aim 2 in May 2019
• Begin work with communities in October 2019 (Aim 3)
• Craft toolkit throughout year 2 (Aim 4)

Caitlin Dickinson, MPH
Project Manager
summerca@ohsu.edu | 971-291-7722
Education

• Build primary care capacity to manage health conditions usually referred to specialty care
  – Support for primary care in communities where specialty care is unavailable
• Education for clinicians, clinical teams, and beyond primary care setting
• Appropriate for broad range of clinical topics
Oregon ECHO Network

**Funding Agencies:** Various

**Project Dates:** Ongoing

**Senior Leadership:** Nancy Elder, MD, MPH and Ron Stock, MD, MA

**Project Manager:** Maggie McLain McDonnell, MPH
What critical gap does this project address?
Project ECHO (Extension for Community Healthcare Outcomes) Components

1. Use Technology (multipoint videoconferencing and Internet) to leverage scarce resources
2. Sharing “best practices” to reduce disparities
3. Case-based learning to master complexity
4. Program evaluation and data tracking
5. All teach- all learn
Oregon ECHO Network

Statewide resource for ECHO programs and services, e.g. supports participant recruitment, evaluation, IT support, faculty engagement and contracting, curriculum development, delivery of sessions, CME, Maintenance of Certification Part 2

www.Oregonechonetwork.org
Oregon ECHO Network and Partners
How will Project ECHO improve health outcomes or equity for Oregonians?

• More patients receive expert-level specialty care in their own communities
• Patients avoid extensive travel for appointments
• Improves patient outcomes
  – Has reduced emergency department use
  – Improved medication safety
• Reduces clinician burnout
• Supports healthcare professionals to continue to practice in rural, frontier, and underserved communities
Reach
Program Evaluation

100% of respondents “Increased the number of collegial discussions with peers about patients with opioid use disorder (OUD) and other substance use disorders”

58% of respondents reported their clinic “changed a policy or procedure to improve care for patients with OUD or SUD”

63% of respondents “provided 1 or more case consultations for a colleague on a patient with OUD or SUD”

37% of respondents convened a “multi-disciplinary group within [their] clinic to discuss improving care for patients with OUD or SUD at least 1 time”
Next Steps

• Continue to offer programs that focus on health professionals’ interests and needs
• Creation of Addiction Medicine Certificate Program
• More ECHOs focused on older adults
• Develop outcomes research agenda
• Continue to engage other funding sources to create a sustainable program
Upcoming programs- Fall 2019

• Adult Psychiatry II
• Geriatrics Behavioral Health in an Age-friendly Health System
• Opioid Prescribing in Dental Settings
• Substance Use Disorders in Ambulatory Care
• Substance Use Disorders in Hospital Care

Ron Stock, MD, MA
Clinical Advisor
stockro@gmail.com

Maggie McLain McDonnell, MPH
Senior Program Manager
mclainma@ohsu.edu

www.oregonechonetwork.org
Education and Coaching

• Combine education with technical assistance
• Tailor coaching to local setting
• Flexible and data-driven strategies
• Applies to several clinical topics where evidence-based interventions exist
Reducing Tobacco Prevalence in Rural Settings – Technical Assistance for Practices and Payers

Funding Agency: OHA – Public Health
Project Dates: 2018 – 2019
Principal Investigator: Anne King
Project Manager: Cullen Conway
What critical gap does this project address?

• Each year, tobacco use in Oregon is responsible for:
  – Nearly 8,000 deaths
  – $2.5 billion in medical expenses, lost productivity, and early death

• Rural populations are especially vulnerable to the effects of tobacco use

• CCOs and clinics are working to reduce tobacco use and attenuate disparities

• This project sought to understand barriers and best practices across CCOs and clinics in tobacco cessation support processes
How will tobacco cessation TA improve health outcomes for Oregonians?

- Helping clinics and communities reduce tobacco prevalence and associated health outcomes
Study Components

- Needs Assessment
  - 33 key informant interviews

- ECHO
  - 18 participating Organizations

- Practice Facilitation
  - 6 primary care clinics
Participants / Setting
ECHO Topics

1. Office-based systems for screening through treatment
2. Tobacco cessation counseling
3. Pharmaceutical interventions
4. Referral to community services
5. Working with special populations (pregnant, elective surgery)
Tobacco Cessation Workflow – East Bend
ASK, ADVISE, REFER: 2 A’s and R

MA
- ASK every patient if they are using tobacco?
  - No
  - Yes
    - ASK if interested in quitting or making changes?
      - No
      - Yes
        - Notify provider by placing tobacco use in chief complaint (OPTIONAL: Place referrals)
          - No
          - Yes
            - Offer handout; interested in any cessation REFERRALS?
              - No
              - Yes
                - PRE WORK
                  - Huddle: MA/BHC identifies patients who use tobacco for follow up

PCP
- Reinforce ADVISE to quit and REFER
  - REFER to follow up with Quit Line, BHC, BHC classes; and/or prescribe medications
    - Follow up on BHC-related referrals by BHC; medication usage by PRA; QL referral by ??

BHC
- Warm hand off or referral to BHC

PharmD
- REFER to pharmacist for complex medication management
Quitting is the most important change you can make for your health!

We’re here to help you!

- Counseling Support
- Group Support
- Quitline—24/7
- Medication

Talk to your provider today!

Mosaic Medical
Want to save $1,825 a year? 
Stop smoking.

Smoked Free Oregon

<table>
<thead>
<tr>
<th>Time since quitting</th>
<th>Money saved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 day</td>
<td>$5</td>
</tr>
<tr>
<td>1 week</td>
<td>$35</td>
</tr>
<tr>
<td>1 month</td>
<td>$150</td>
</tr>
<tr>
<td>1 year</td>
<td>$1,825</td>
</tr>
<tr>
<td>5 years</td>
<td>$9,125</td>
</tr>
</tbody>
</table>

Quitting is easier with help.

Call: 1-800-QUIT-NOW (1-800-784-8669)
Español: 1-877-2NO-FUME (1-877-266-3863)
https://www.quitnow.net/oregon/

Name ________________________________ DOB __________________

This patient with a history of tobacco use has an appointment to see you today ________. Studies show that tobacco cessation counseling in the primary care setting can be effective. Counseling can include:

- Ask permission to discuss tobacco cessation.
- Assess readiness to quit.
- Advise patient to quit.
- Assist the patient who is ready with a quit plan.
- Arrange for follow up visits.

As appropriate, use the following visit codes for time spent counseling:

99406 3-10 minutes
99407 greater than 10 minutes
Early Findings and Recommendations

1. Training in workflow development and standardization in tobacco cessation best practices
2. Increased human resources integrated in primary care clinics
3. Implementation of e-referrals to Quit Line to create a closed-loop referral system.
Next Steps

• Stay tuned for Healthy Hearts Northwest (H2N) sessions and discussion

• Contact me with any resource requests

Cullen Conway, MPH, CCRP
Research Associate & Portland-based PERC
Oregon Rural Practice-Based Research Network
Oregon Health & Science University
Phone: 503-679-0455
conway@ohsu.edu
Large-scale demonstration projects

- Multi-state projects having significant local impact in Oregon
- Funding through Centers for Medicare & Medicaid Services
  - Payment innovation to support practice transformation
  - Filling a critical gap between clinical care and community services for health-related social needs
Comprehensive Primary Care Plus

Funding Agency: Centers for Medicare & Medicaid Services
Project Dates: 2017-2022
Principal Investigator: David Dorr, MD, MS, FACMI
Project Manager: Martha Snow, MPH
What critical gap does this project address?

- 18 regions
- 2,900 PCPs
- 56 aligned payers
- Reimbursement Reform
  1. Medicare Physician Fee for Service
  2. Care Management Fees
  3. Performance-Based Incentive Payment
Examples of CPC+ Activities

**Access and Continuity**
- 24/7 patient access
- Assigned care teams
- Alternative care delivery approaches (e.g., eVisits, group visits, home visits)

**Care Management**
- Risk stratified patient population
- Short and long-term care management
- Care plans for high-risk chronic disease patients

**Comprehensive and Coordinated Care**
- Identifying high volume/cost specialists serving population
- Follow-up on patient hospitalizations
- Behavioral health integration
- Psychosocial needs assessment and inventory resources and supports

**Patient and Caregiver Engagement**
- Convening a Patient and Family Advisory Council
- Supporting patients’ self-management of high-risk conditions

**Data-Driven Population Health Management**
- Analysis of payer reports to inform improvement strategy
- At least weekly care team review of all population health data
How will CPC+ improve health outcomes for Oregonians?

• 152 Practices
  • 32 Independent
  • 30 Rural
  • 23 Small Practices

• 1,081 Practitioners

• 118,982 Medicare beneficiaries
  • 100,000s other insurance beneficiaries
Oregon Partners

CPC+ Oregon Payers

School of Medicine
Care Management Plus

Other Partners

InterCommunity Health Network CCO
UnitedHealthcare
PrimaryHealth
moda HEALTH
Yamhill COMMUNITY CARE
AdvancedHealth
PacificSource HEALTH PLANS
Trillium Community Health Plan
CareOregon
PROVIDENCE Health Plan
HealthInsight
OREGON HEALTH CARE QUALITY CORPORATION
CollectiveMedical

Oregon Rural Practice-Based Research Network
Next Steps

• Share local knowledge, networking, resources, and events
• Support QI projects
• Host biannual CPC+ Conferences
• Phone, virtual, and in-person site visits
• Build partnerships and elevate concerns to stakeholders

Martha Snow, MPH
CPC+ and CAPTURE Project Manager
snowm@ohsu.edu
Accountable Health Communities:

- Screening for 5 health-related social needs: housing, food, utilities, transportation and interpersonal violence.

- Connecting patients with social needs to community services

- Developing tailored referral and care plan for “high risk” patients

- Integration activities
Project Update

1. We started 12/10!
2. Need additional volume of screens/navigations to get to 75K/3K.
3. Portland metro area clinical sites now invited to join project
Primary Research Question

• Does screening for social needs plus tailored navigation to health and social services lead to improved outcomes and reduced costs of care?

• Other questions...
  • Prevalent social needs
  • What needs are not being met & why
  • Best approach to this work
  • Etc.
Survey Results (from early data)

- Food Questions:

  **Medicaid:**
  Within the past 12 months, you worried that your food would run out before you got money to buy more (N=90)

  - Never True: 49%
  - Often True: 33%
  - Sometimes True: 18%

  **Medicare:**
  Within the past 12 months, you worried that your food would run out before you got money to buy more (N=51)

  - Never True: 92%
  - Often True: 8%
## Survey Results (from early data)

<table>
<thead>
<tr>
<th>Issue</th>
<th>Medicaid</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>“High Risk”—2 or more ED visits in prior year</td>
<td>33%</td>
<td>12%</td>
</tr>
<tr>
<td>No steady housing or concern about losing housing</td>
<td>19%</td>
<td>2%</td>
</tr>
<tr>
<td>Lack of reliable transportation to medical appointments, meetings, work or getting to things needed for daily living</td>
<td>13%</td>
<td>0%</td>
</tr>
<tr>
<td>Utility companies (electric, gas, oil or water) have threatened to shut off services</td>
<td>24%</td>
<td>4%</td>
</tr>
</tbody>
</table>
Survey Results (from early data)

- Safety Questions

Medicaid Members

- How often does anyone, including family and friends, insult or talk down to you?
- How often does anyone, including family and friends, scream or curse at you?
Survey Results (from early data)

- Safety Questions

How often does anyone, including family and friends, insult or talk down to you?

- Never: 84%
- Rarely: 18%
- Sometimes: 12%
- Fairly Often: 10%
- Frequently: 0%

How often does anyone, including family and friends, scream or curse at you?

- Never: 70%
- Rarely: 20%
- Sometimes: 4%
- Fairly Often: 2%
- Frequently: 0%
Survey Results (from early data)

• Safety Questions

Medicaid Members

- How often does anyone, including family and friends, threaten you with harm? (92% NEVER, 97% NEVER)
- How often does anyone, including family and friends, physically hurt you? (3% NEVER, 2% NEVER)
Survey Results (from early data)

- Safety Questions

**Medicare Members**

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Fairly Often</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often does anyone, including family and friends, threaten you with harm?</td>
<td>98%</td>
<td>2%</td>
<td></td>
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<td>How often does anyone, including family and friends, physically hurt you?</td>
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<td>100%</td>
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Future Data Analysis

• Analyze results by demographic factors, population subsets, region, zip code, etc. & share with stakeholders

• Data dashboard and clinic reports
Webinars- now available online

1. “Empathic Inquiry: Screening Patients for Social Factors in a Patient-Centered Way” - OPCA & Rogue Community Health
   - https://vimeo.com/315959674

2. “Screening for Safety in AHC Sites” – Tillamook Women’s Resource Center
   - https://vimeo.com/316619308

3. “Health Literacy and Cultural Considerations” – PacificSource
   - https://vimeo.com/317319849

4. “Screening for Housing & Utilities Insecurity” – The Curry Homeless Coalition & Sol Coast Consulting & Design
   - https://vimeo.com/315962780

5. “Screening for Food Insecurity” – Oregon Food Bank
   - https://vimeo.com/315963511

6. “Screening for Transportation Needs in AHC Sites” – OHA
   - https://vimeo.com/315963830

The **password** to access all of the webinars is: OregonAHC201819
Thank You!

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How to get involved

• Join a study
  – CAPTURE (COPD)
  – CASCADE (atopic dermatitis)
  – Accountable Health Communities (social health determinants)

• Participate in education
  – Colorectal cancer screening workshop on May 31
  – Oregon ECHO Network: go the website to learn more

• What topics interest you? In the pipeline for us
  – Screening for alcohol misuse
  – Lung cancer
  – Behavioral health and diabetes management
Thank you to our presenters!

Connect with us to get involved.