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Oregon Partnership for Health Integration

Portland, Oregon

PARTNERS

- Cascadia Behavioral Healthcare (Primary Grantee/Mental Health/Wellness Activities)
- Outside In (FQHC/Medical Van)
- PSU Regional Research Institute (Evaluation)

Presented at PBHCI Grantee Meeting, Phoenix, AZ
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PROGRAM LEADERSHIP

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Population(s) of Focus

- Co-occurring addiction & mental health diagnoses
- Currently homeless or have a history of homelessness

Primary Population(s)

- High behavioral health and low physical health needs (Quadrant II)
- High behavioral health & high physical health needs (Quadrant IV)
- No primary care services

Why?

- Increased barriers to engagement in services
- Less likely to access services

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Implementation Practices

Tailor health services for specialized needs and preferences

- Transitional & permanent supportive housing, case management, & outreach
- On site medical services weekly at each program
- Peer Wellness Coaches available on site and by phone
- OPHI recruitment/engagement partners include housing & street outreach

A prepared workforce

- Cascadia and Outside In have strong homeless services programs & experience serving individuals with co-occurring disorders
- OPHI Team meets twice daily to discuss current cases and needs
- OPHI stakeholders meet twice monthly to review progress and plan for future

Implementation Practices

Reaching out to subpopulations

- Cascadia policy includes federally mandated CLAS standards, including diverse cultural health benefits & practices, preferred languages, health literacy, & communications needs
- OPHI program goals are client-centered and client-driven
- Partner organizations collaborate in outreach to clients in target populations and to identify barriers/resources
- Reminder calls for primary care appointments, lab work, 1:1 meetings with PWCs and/or nurses and groups, and accompanying clients to off-site appointments
- Monthly OPHI team meetings to review data and evaluate current practices
- Starting 2014, enrollment of OPHI participants into Oregon's new statewide insurance program

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Initial Challenges and Barriers

1. **Integrating data systems from two different organizations**
   Solutions: data sharing agreements, involving IT staff in initial planning process, graduated plan to merge data systems.
2. **Increasing comfort level of people with mental health diagnoses and homelessness in accessing medical care**
   Solutions: use of Peer Wellness Specialists, friendly and compassionate staff, tours of medical van, staggered introduction to medical care, opportunities for OPHI staff meet and greet at various program sites.
3. **Low enrollment/engagement due in part to client mobility and mental health diagnoses**
   Solutions: adding additional sites earlier in process, changing van schedule, increasing peer outreach, consultation with partner organizations experienced with target sub-populations, partnership with outreach teams.

Data & Collection Measures

Health outcome goal

Reduce prevalence of chronic physical and behavioral health challenges among target population, especially people who are homeless and/or experience co-occurring addiction and mental health challenges.

Data collected at intake, every 6 months, and at discharge

- In person interviews: housing status, mental health symptoms, substance use, and other sub-population demographics
- Health measures: blood pressure, BMI, waist circumference, breath CO
- Labs (annually): plasma glucose, cholesterol, tri-glycerides
- OPHI program participation (at follow-up)
- OPHI program feedback (at follow-up)

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Data & Collection Measures

Reviewing measures for planning purposes

Bi-Annual reviews by program staff:

- NOMS health measures broken down by gender, ethnicity, race, primary language, disability status and LGBT status.

Quarterly reviews by clinical team:

- Physical healthcare diagnosis broken down by age & gender, race/ethnicity, broad mental health category diagnosis

Comparison samples:

- Outcomes of identified sub-populations will be compared to the overall total number clients in the program, local populations and health data rates in your area when available, & with national statistics for these populations

Successes to Date

Trained full time staff: RN Care Coordinator & two Peer Wellness Coaches

- Peer Wellness Coaches (PWC) trained to facilitate *Living Well With Chronic Conditions*
- PWCs trained in NOMS data collection and measuring mechanical vitals
- PWCs and RN Care Coordinator completed 12 hours of *Motivational Interviewing* training

OPHI Services began February 1, 2013

- Outside In mobile medical van serves OPHI clients two days/week
- A growing range of services including primary care, 1:1 meetings with PWCs, care coordination by RN, groups (Living Well with Chronic Conditions; Learn About Healthy Living; Yoga, Art, Jive and Mo!; LOTUS; Weight Management and Nutrition), and acupuncture
- Monthly multidisciplinary team meetings

Looking Ahead

- Adding two more program sites October 2013
- Continuing outreach and engagement with target populations for increased enrollment
- Providing additional training for mental health staff on integrated care practices and physical health conditions
- Continuing development of community partnerships
- Exploring process for Woodland Park Outpatient Clinic to become first behavioral health home in the state of Oregon

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