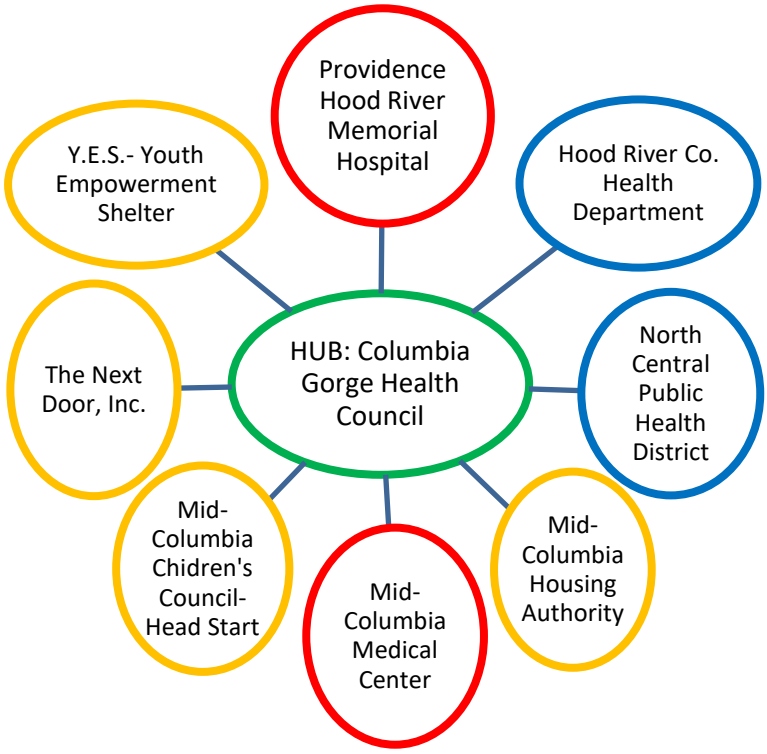
Bridges to Health Pathways

A cross-sector collaborative approach to providing community care coordination



Community Care Coordinators (CCC's) are Community Health Workers or equivalent and are employed by the Community Care Agencies (clinics, hospitals, health departments, social service agencies) and help coordinate needed services for clients & their households.

Agencies contract with the HUB to get paid when evidence- based outcomes are met.

Current Target Population: HOUSING CHALLENGED

CORE PATHWAYS (Needs)

- Behavioral Health
- Developmental Screening
- Developmental Referral
- Medical Home
- Medical Referral
- Health Insurance
- Medication
- Pregnancy
- Postpartum
- Family Planning
- Tobacco Cessation
- Education
- Food
- Immunization
- Employment
- Housing
- Social Service Referral (transportation, debt management, utility assistance, legal, documentation, etc.)

Bridges to Health Pathways Program Goals:

Ability to address the needs of the **HOUSEHOLD**

Build on community strengths and collaboration

Engage clients where they are, "no wrong door" approach

Maintain a standard process regardless of agency clara

Limit duplication of services

Support data-driven decision making

- ✓ Original grant funding: Meyer Memorial Trust, Oregon Community Foundation, Providence CTC, PacificSource grants and CCO funding
- ✓ Scope includes pathways designed to meet cross sector metrics (healthcare, early learning, education, public health)
- ✓ "Housing Challenged" is the criteria to get enrolled (doubling up, transportation concerns, inadequate square footage, struggling to cover rent, at risk of losing home, unsafe housing situation, homeless, etc.)

Bridges to Health Pathways:

CHALLENGES	OUR SOLUTIONS
HIPAA regulation and interpretation- cross sector collaboration involves HIPAA covered entities and non-covered entities	Data sharing agreements, providing HIPAA training and certification for those outside healthcare
True COMMUNITY care coordination takes time – building relationships, trust	Reminder: we are DOING WORK DIFFERENTLY, INNOVATION is exciting and scary, share data on outcomes to encourage collaboration
Software Challenges- Double data entry, discomfort with technology, time consuming	Incorporate time for data entry into the work and pay for it
Healthcare is typically provided in an office- Care Coordinators are in the "office" <½ the time, out in the community	Provide lots of opportunity for good communication- team meetings, status reports, trainings
Proving program success takes time- Value qualitative data, start with process outcomes, measure success amongst all partners, plan for a three year runway	Leap of faith by PacificSource Community Solutions using health plan spending to commit to well being PacificSource Community Solutions

SUCCESSES
Clients are met where they are most physically comfortable and empowered to prioritize needs most important to them
Community Health Work aids in recognizing and eliminating disparities in care
Shared data systems and process allow for a data driven decision making approach to recognizing and addressing systemic inequities and barriers to care
Cross sector partnerships break down silos, build relationships, avoid duplication of services- better client experience
Provides healthcare with a lens outside the walls of the system
Health plan funding is possible

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