



The Community Health Workforce: Taking Health to the People

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Name of project or collaborative

Health Resilience Program™ of CareOregon

Geography

Oregon

Brief description

In partnership with safety-net practices, CareOregon developed a new model of Community-Oriented Primary Care that travels beyond the four walls of the medical office practice and reaches into the community where our city's most vulnerable residents live their lives, trying to navigate a complex web of services that is anything but user-friendly.

Program Focus:

We believe that providing the health care system with a new workforce of non-traditional health care workers - Health Resilience Specialists (HRS) who are Master's level 'engagement specialists' tasked with developing meaningful partnerships with a panel of high-acuity/high-cost patients to enable wellness and stability in their lives – will reduce the total cost of care and enhance patient experience and outcomes.

Programmatic Guiding Principles:

Reduce Barriers: By avoiding lengthy assessment process or asking for personal information before a relationship is built.

Client Centered: Meeting the client/medical staff where they are; collaborate on client and programmatic goals.

Transparency: HRS is open about intentions and does not withhold information either with client or providers.

Take time and Build Trust: We do not work on a billable hour's model which means we can build a relationship at the client's pace. We are honest and transparent and offer choices as well as collaborate.

Avoid judgment and labels: "drug abuser", "non-compliant".

Community based: reach out to client in their settings thus providing non-hierarchical setting, which encourages sense of safety and trust.

Target Population:

Health Resilience Program has a specified target group whose screening characteristics are as follows:

- Established in a clinic where Health Resilience Specialist (HRS) is embedded
- CareOregon or Providence Medicaid coverage
- Is living in the Portland, Tri-County area
- Willing and able to make a change in their lives
- Recent, modifiable utilization patterns; 18 yrs or older

- One or more non-OB hospitalization admissions with or without ED visits within 12 months OR six or more ED visits with or without hospitalization within 12 months

Secondary population considerations within the enrollment group:

Often unrecognized psychosocial factors contribute to patient's health challenges. Many of these are formally identified after the patient is engaged, such as:

- High prevalence of trauma in their lives (past and/or present) and, as a result, may have difficulty problem solving and planning proactively
- Distrust of traditional authority figures
- Inability to connect with previous primary care services and/or relate to previous clinical providers
- Inadequate access to psychiatric assessment and mental health services (which can be a driver of the utilization referenced as a primary driver/patient identifier)
- Higher than average incidence of addiction
- Culture of poverty, and/or frailty
- Cognitive and health literacy challenges
- Social Isolation and Depression

Build trust with and walking alongside the patient is crucial; as such, utilizing non-traditional engagement strategies is critical to building trust.