Better Outcomes thru Bridges (BOB) Programs

Utilizing Peer Support, Outreach and Community Partnerships to help our most vulnerable behavioral health patients access needed services

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What is BOB?

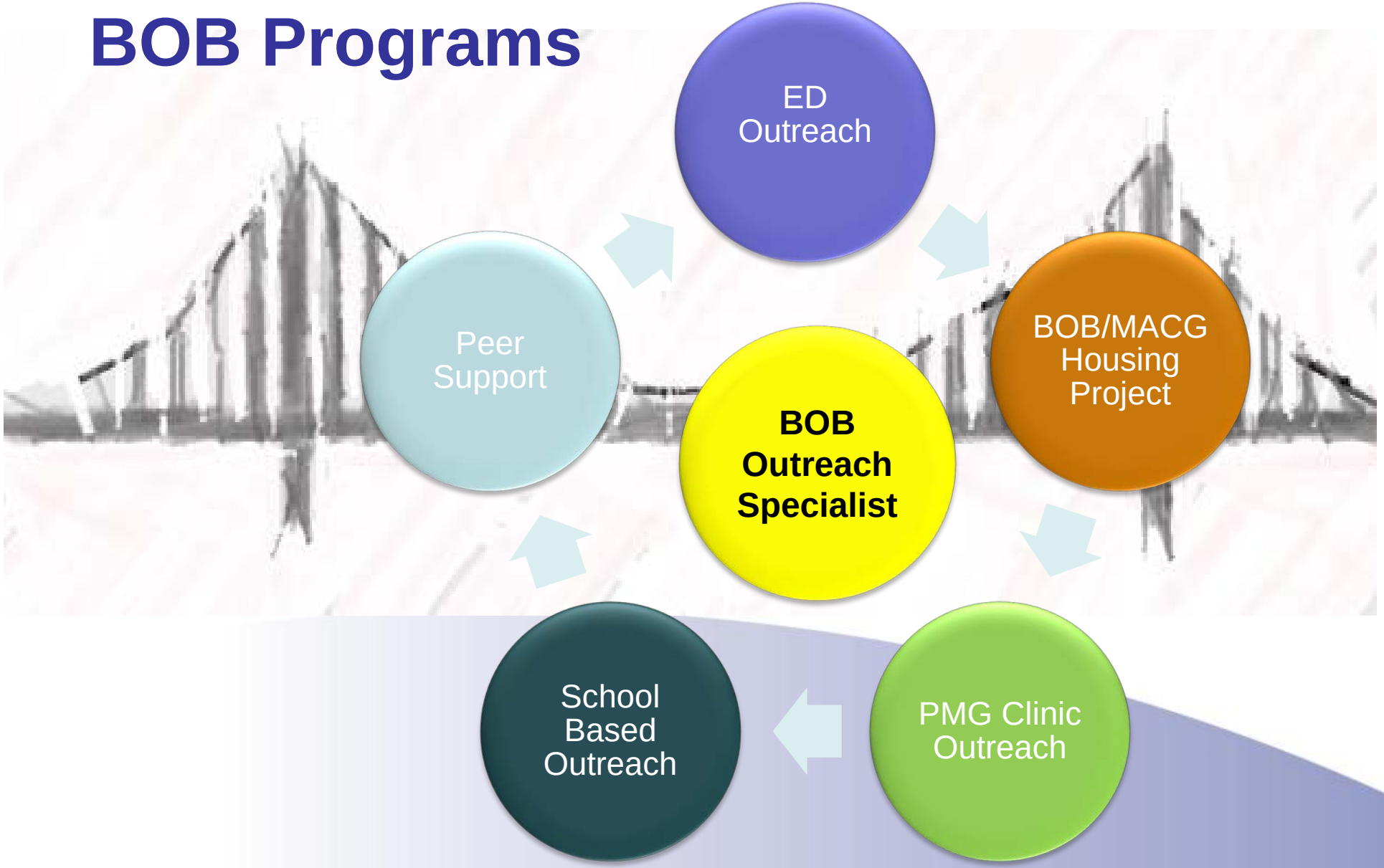
Serving some of our most vulnerable patients.

Our goal is to empower individuals in their journey toward better well-being, by treating all people with compassion, dignity, and respect while helping them guide their own care.

We walk alongside clients to help ease their way;

literally and figuratively meeting clients where they are at.

BOB Programs



Emergency Department Outreach

Patient has had 6 Emergency Department visits within a 6 week time frame, primarily at Outreach Specialist's home hospital

OR

Patient has had 20 or more Emergency Department visits within the past 12 months, primarily at Outreach Specialist's home hospital

AND

Patient has one or more of a Mental Health, Substance Use and/or Chronic Pain diagnosis

Interventions, Philosophies & Innovative Practice

- ED Specific Multi-Disciplinary Team Meetings
- Innovative Solutions
- Meeting patients where they are at
- Understanding the trauma of our systems and our clients
- Redefining success
- Becoming a change agent
- Cultivating Relationships!

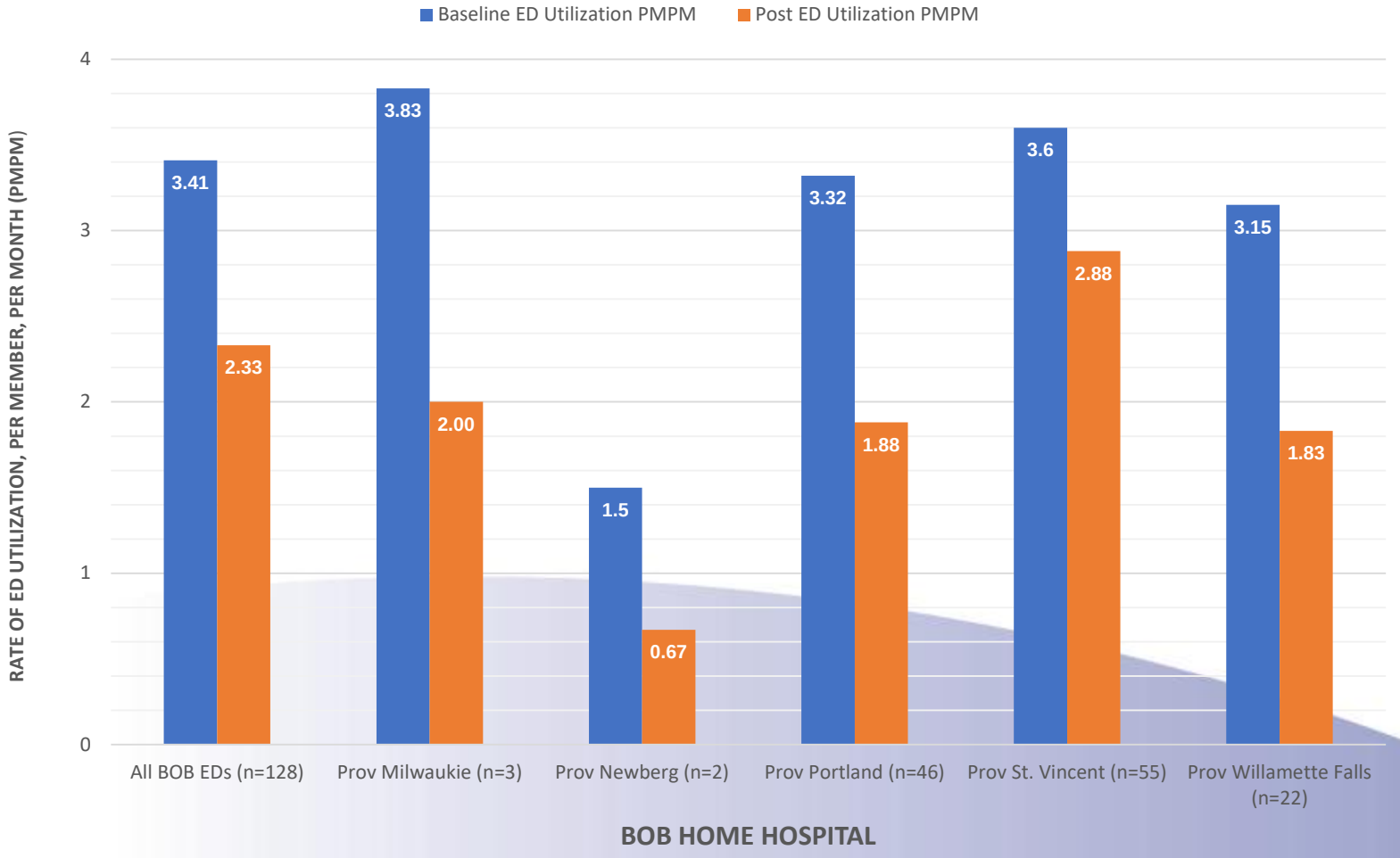
2019 Q2 YTD BOB Program Outcomes

42%

BOB Clients who showed a 50% reduction in ED utilization

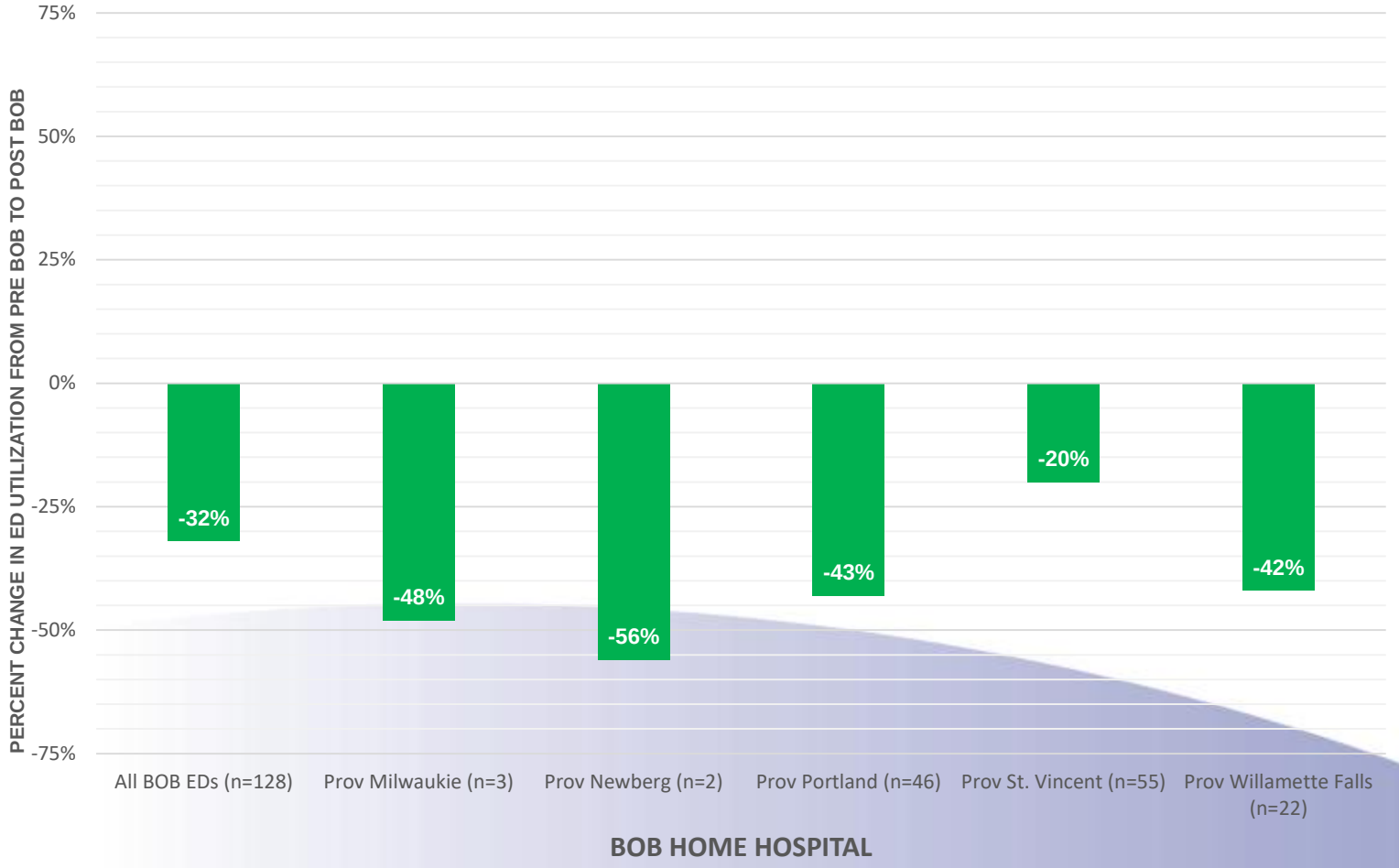
PROVIDENCE

2019 BOB Program
ED Utilization Pre vs Post BOB Intervention
BOB start date between 7/18-6/19



2019 BOB Program: Percentage Change in ED Utilization Pre vs Post BOB Intervention

(7/18-6/19)



ED Outreach Data

Better Outcomes thru Bridges (BOB) & Homelessness

BOB ED Clients Identified as Homeless
(or facing imminent homelessness)

BOB ED Homeless Clients
Connected
to Stable Housing by BOB Team

BOB/MACG Safe Overnight Shelter Project
A Partnership is Born

In 2018, BOB met with the Metropolitan Alliance for Common Good Clackamas Housing Team.

They wanted to introduce Safe Overnight Shelter Model into the area but lacked case management.

PROVIDENCE Health & Services

MACG metropolitan alliance for common good

BOB/ MACG Housing Project

Partnering with Host Sites

Safe Overnight Shelter Models hosted on various properties in and around Clackamas County

The BOB Outreach Specialist can provide case management for all shelter guests at host sites

In exchange, guest slot(s) will be reserved for individuals referred from Providence hospitals

Thinking Outside the Box

- Community-driven solutions, responsive to community needs
- Smaller, scattered-site shelter models are quicker and less expensive to create
- Models allow flexibility: no permanent structures are created, programs can be moved, ended or modified in a short period of time

Agape Village Partnership

Strategic Partnerships: The Housing Story Project

The Housing Story Project is an interactive educational display created by Storyline Community sponsored by the BOB/MACG Clackamas County Housing Team.

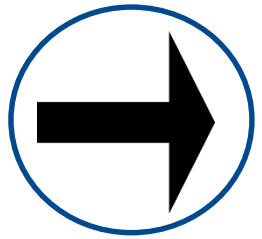
This walk-through display presents factual statics about the housing crisis in Clackamas County, and includes information including median renter wage and median income, housing supply, and homelessness in specific Clackamas County areas

What we have done

- ✓ PWF Outreach
- ✓ Outreach and Education to 24 churches in person and over 100 via email/phone
- ✓ Inspiration for PNH Car Camping and Tiny Home village
- ✓ Clackamas County Affordable Housing Grant expansion/PMH
- ✓ Best Practices ToolKit
- ✓ Educational Hut
- ✓ Open House Event
- ✓ De-escalation, Training and support skill building for church members

What we are doing

- ✓ Clackamas County Parks
- ✓ Multnomah County sites
- ✓ Land Use hearing for 1st site
- ✓ Agape Village tiny home Partnership
- ✓ Cultivating many various city, county and community partnerships
- ✓ Housing Story Project
- ✓ PWF Pilot



Where we are going

- ✓ Partnership with city of Milwaukie
- ✓ Clackamas County site partnership
- ✓ Providence Ministry site pilots & policy
- ✓ Co-Chair MACG Clackamas County Housing Team
- ✓ City of Portland SOS site pilots

CLIENT STORY

When Johnnie met with our BOB Outreach Specialist at the end of April this year, he was homeless and had a multitude of chronic medical issues. He is a veteran and had been living on the street for about 5 years. He had been referred to the BOB program having 6 ED visits and 3 inpatient hospitalizations in the 6 weeks prior to referral.

He was coming into the emergency department often with issues related to years of living on the street and his untreated chronic medical issues. He suffers from heart failure, diabetes and suspected dementia.

In a community wide collaboration, the BOB Outreach Specialist was able to coordinate with many service providers including the VA, housing case managers, primary care clinic staff and the county to get Johnnie much needed services. Through this coordination, advocacy and support for Johnnie, his overall health and well-being have improved and he has had 0 ED visits and 0 hospitalizations in the past 3.5 months.

With the collaboration of the BOB team and community partners, Johnnie is now housed and happily enjoying his new apartment.

Addressing Community Needs Together

Creating and cultivating client, organizational & community relationships that assist in providing innovative solutions for clients well-being

Homeless Solutions Coalition of Clackamas County

Agape Village

BOB ED Site Multi-Disciplinary Team meetings

Regional Coalition for Cross System Innovation

Community Outreach Meeting Group & Resource Listserv

Managing High ED/EMS Utilization

Metropolitan Alliance for Common Good Clackamas County Housing Team

PROVIDENCE

Community Outreach Meeting

Created on the principle that “together we can do great things”, this grassroots alliance made up of many local agencies within the 4 surrounding counties and beyond, meet each month to explore topics such as best practices and community resources.

We also maintain a resource sharing listserv of approximately 1,000 community partners from almost two hundred agencies for the group; which enables us all to better support the individuals and populations they serve.

BOB Providence Medical Group Newberg

PROVIDENCE Health & Services

Internal Medicine

PMG Behavioral Health Team

Criteria: high risk with demonstrated difficulty accessing care related to social determinants

Risk Factors: Behavioral Health presentation

Population: PMG Newberg

Data Source: All to receive AHC Screener

Referring Clinician:

- PMG BHI Team

Social Determinants of Health

Criteria: 2 ED visits, AND 1 or more identified risk factors

Risk Factors: Transportation, Housing, Food, Utilities, Violence

Population: all PMG patients

Data Source: Accountable Health Communities Screener

Referring Clinicians:

- PMG Team

Family Medicine

ED Utilization

***Criteria*: 6 ED visits in 6-weeks or 20-year**

***Data Source*: Epic, EDIE Reporting**

***Referring clinicians*:**

- **PMG Case Managers**
- **ED Staff**
- **PMG Team**
- **Community Partners**

Overview:
Accountable Health Communities Navigation

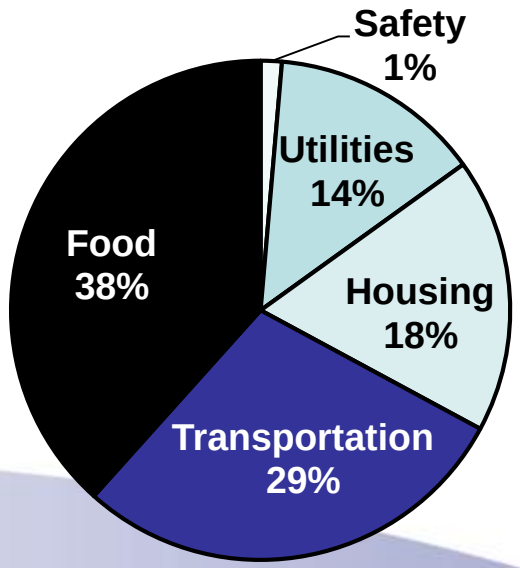
- Approximately 10% of those screened are eligible for navigation
- Approximately 8% accept
- Thus far, 101 patients have been eligible for navigation and 83 have accepted
- Navigation can last up to a year; so many are still in progress

Needs Navigated

- 73 needs were navigated

- Top needs identified:
  - Food, 38%
  - Transportation, 29%
  - Housing, 18%

Distribution of Needs



Needs Navigated

Thus far, navigators have closed 73 needs:

- 61 needs identified by patients have been addressed at this point in time
- 9 needs are being worked on by social service agencies and should be addressed within 6 months
- 4% (3) have been closed, but not addressed because:
  - Patient does not qualify for the service (3)

“Kevin”

Behavioral Health Clinic Referral

In need of housing

History of

- **Substance use**
- **Chronic Pain**
- **Felony on his record**

Newberg School Outreach
What we do…

- In-school social support to students
- Liaison between school staff and parents
- Assist parents and teens with accessing community resources
- Collaborate with other local agencies

Peer Support Outreach Specialists

Utilizing Lived Experience to Help Others

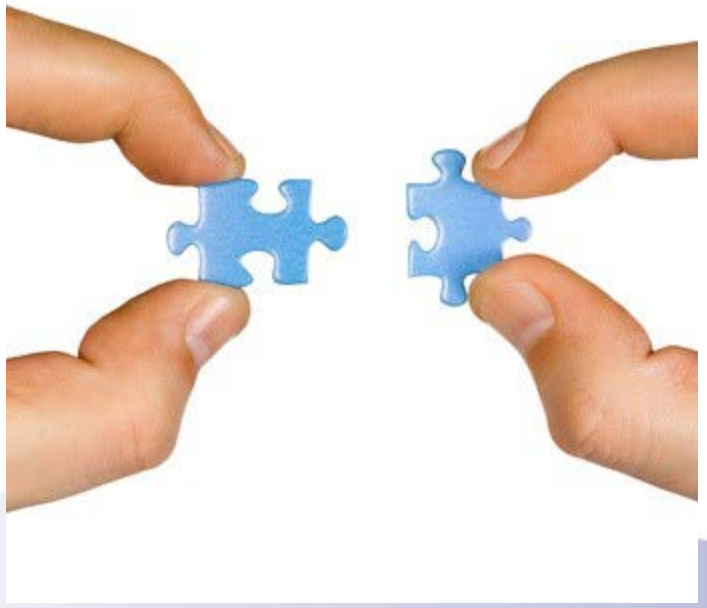
- ED Follow up Calls
- Peer Support- meeting people where they are at
- Network with Community Partners
- Provide support to 6 Providence Hospitals

Caring Contacts and Peer Support

Beyond Caring Contacts

Relationship Building

Employment



Connection to Services

Housing and Shelter Programs

Support

Dear BOB Team,

I wanted to send a personal thank you for all the support you have given me through my transition into the housing program at the Blackburn Center. You guys were there for me when everyone else turned their back. I want to give a special thank you to DJ Alex. She walked beside me every step of the way and if it wasn't for her, I don't know where I would be today.

In the beginning of August, I was ready to end my life. I was living on the streets after getting kicked out of my sober house for relapsing on methamphetamines. I had nowhere to turn. I lost all hope. Someone suggested that I go to the emergency room at Providence in Portland instead of throwing in the towel. I left there with a list of resources and a City Team voucher. I felt so alone! The day after I discharged, I received a call from DJ Alex at Providence. She said she was a peer support outreach specialist and that she was calling to see how I was doing. Calling to see how I'm doing? My first thought was "why would she care how I was doing"? She kept me on the phone for 45 minutes that morning and set up a time to meet with me that very afternoon. For the first time in months, I found some hope. I didn't want to die! I was ready to live!

You see, I have been trying to get sober since 2012 after using for over 20 years. I have graduated numerous treatment centers and had solid transitions plans, but within 6 -9 months, I would relapse. I refused MH services, took only some of the suggestions in the recovery community, and before long I would find myself back in the life I've been trying to get away from. The BOB program helped me save my life! Today, my children have their father and I have more community support than I ever have. I am living my best life today! Again, thank you so much for not giving up on me.

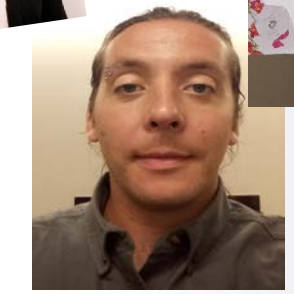
Sincerely grateful,

Mark Meeks
Clean date: 7/31/19

Where do we go from here?

The Team



Brave is Beautiful
HEAL
connect
relating
love
balance
thrive
STAND UP FOR US ALL
GROW
Hope
NAVIGATOR
Story
POSSIBILITIES
BREAKING DOWN THE BARRIERS
SIMPLE
balance
LIVING
Love Myself
Puzzle of Power
passages
relating
solve
FRESH
YOU LIGHT THE FIRE, WE'LL PAVE THE WAY
ON A MISSION




Questions or Comments

Thank you for your time!