Bridging Transition Age Youth into Healthy Futures: A Population Health Approach to Meeting Youth Needs

PRESENTATION TO 2016 CCO SUMMIT

FamilyCare Health

Definitions for TAY Space

Transition Age Youth- (TAY): Any youth between the ages of 15-25. (Definition from CHIP).

FamilyCare Members = 18,298.

CHIP focus on high utilizers or ‘hot spotters’

Opportunity Youth

Subset 16-24.

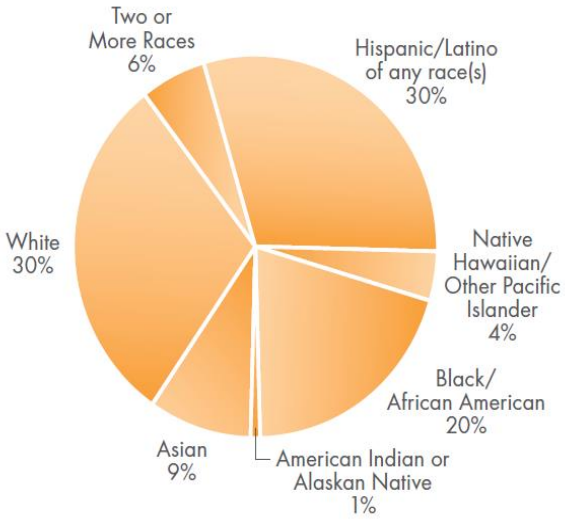
Young people who are disconnected from education and employment, including those who have been involved in the justice and/or foster care systems, have been dubbed “opportunity youth” in recognition of their tremendous untapped potential.

N=68,214 in the state of Oregon.

Who are these Youth

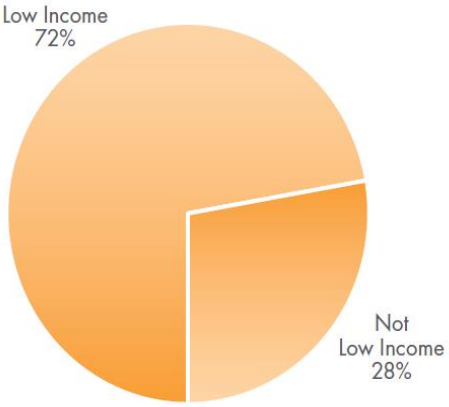
WHO ARE OUR OPPORTUNITY YOUTH?

Racial/Ethnic Profile



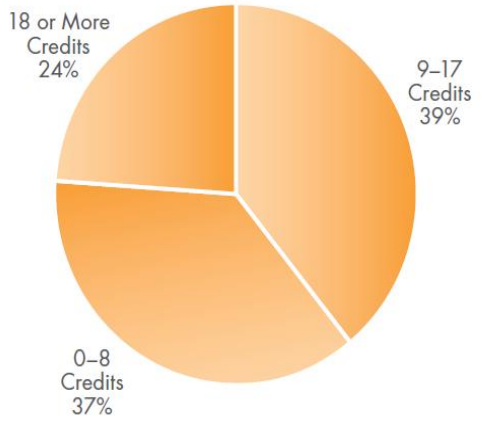
About half of our Opportunity Youth are Hispanic or African American. One third are White students.

Income Status



Nearly three quarters come from a low-income background.

Credits Earned



Most youth who leave high school without a credential are significantly credit deficient. However one quarter have 18 or more credits when they leave.

Why a Community Health Improvement Plan focus on Transition Age Youth?

The Road to Bridging the Gap

Foundational assumptions for TAY strategy

- Asset-based – both intervention AND prevention focused. Build upon the assets of the individual, the community and the organization. High emphasis on partnership as tool for leveraging resources for early wins and deep holistic work.
- Equitable- designed to level the playing field for vulnerable populations
- Community-driven and research based (evidence based where the evidence is population and culturally relevant).
- Data Driven- continuous improvement and process evaluative
- Key is alignment with pre-existing community collective efforts- add value of data and health lens.

Core Principles/Social Determinants

All young adults have access to affordable, safe, and stable housing

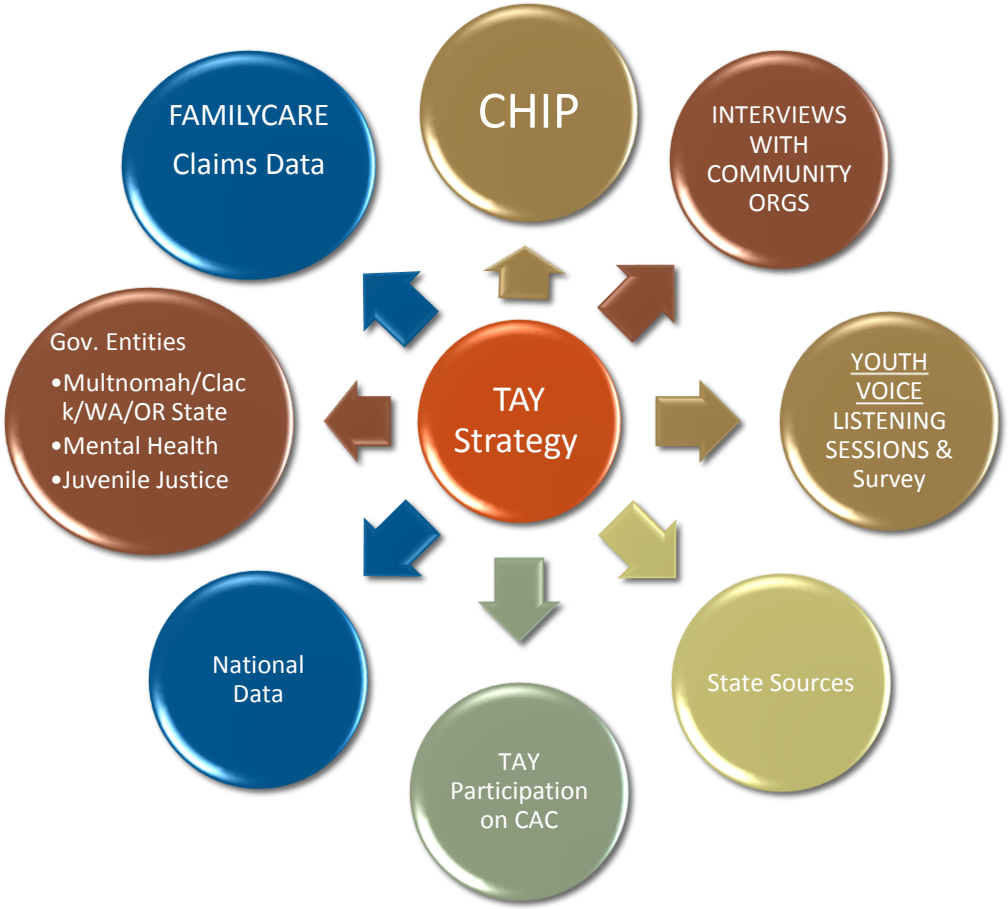
All young adults are physically healthy & emotionally resilient

All young adults attain educational achievement in preparation for career and community participation, including a high school diploma, postsecondary degree and/or vocational certificate training

All young adults are gainfully employed with living wages and benefits and/or have access to career training to achieve life-long economic stability and greater health

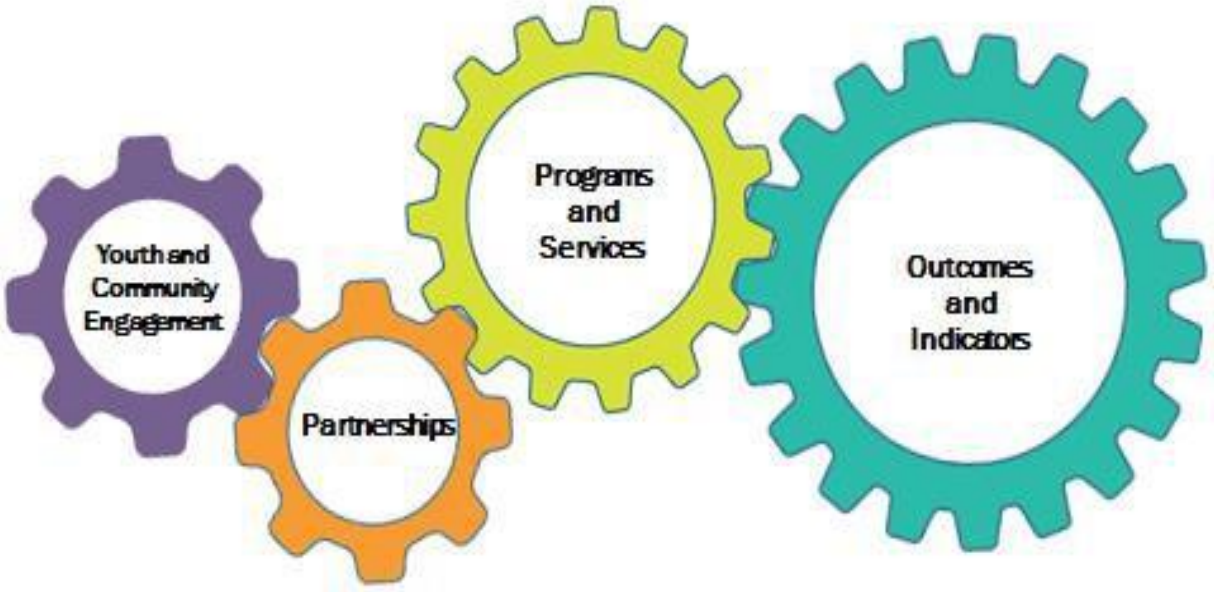
All young adults have connections to a positive support system, including guidance from family members and caring adults

Sources for Strategy Development



Data Points

Quantitative	Qualitative	
• # of members • # of ER Visits • # of Urgent Care Visits • # of members with assigned PCP • # of PCP Visits • # of AWC Visits • # of members transitioned into suitable care-based on acuity	• Identified barriers (CBO/TAY) • Identified needs (CBO/TAY) • Identified assets • Increased partnership for impact	
Social Determinants of Health		
• Education • Employment • Housing • Food Security		


Youth and Community Engagement
Partnerships
Programs and Services
Outcomes and Indicators

Youth and Community Engagement

- Community Health Improvement Plan (CHIP)/Community Advisory Council (CAC)
- Listening sessions with TAY youth
- On-going learning through Professional Learning Communities tied to RFP Process.

Partnerships

- Pre-existing Providers-Community Based Organizations whose work can be deepened and supported
- Join collective pre-existing efforts happening in communities (e.g. Youth Success Institute Funders Group; All Hands Raised; Homeless Youth Continuum)
- Utilize RFP to encourage and fund collective efforts across TAY serving populations including shared outcomes and data sharing efforts to get clearer picture.
- Partner with youth- existing councils

Targeted outcomes:

Increase health literacy and wellness knowledge

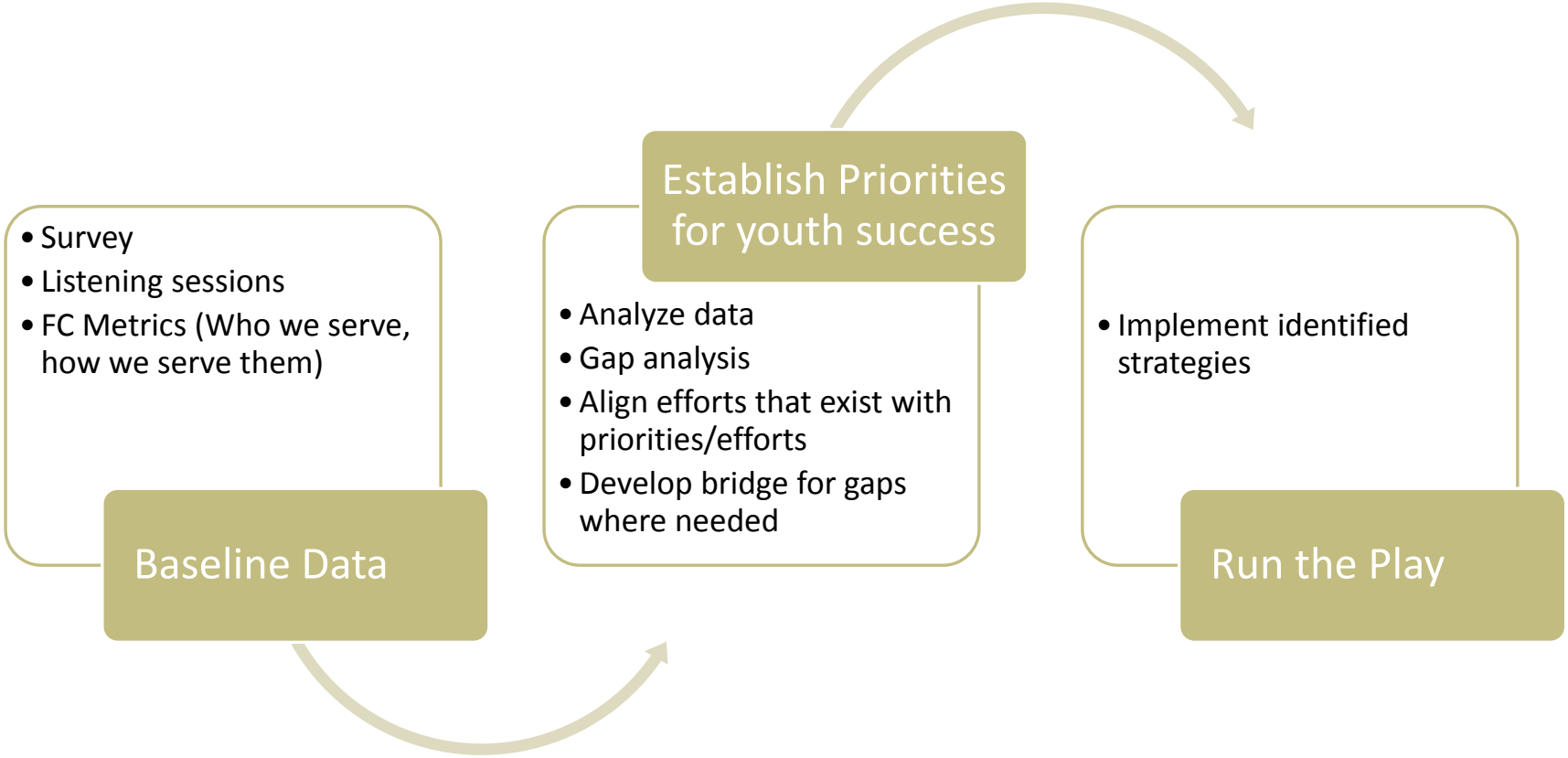
Increase engagement in health and health care

Increase cultural competence in health care systems. Better operationalize systems around the TAY population

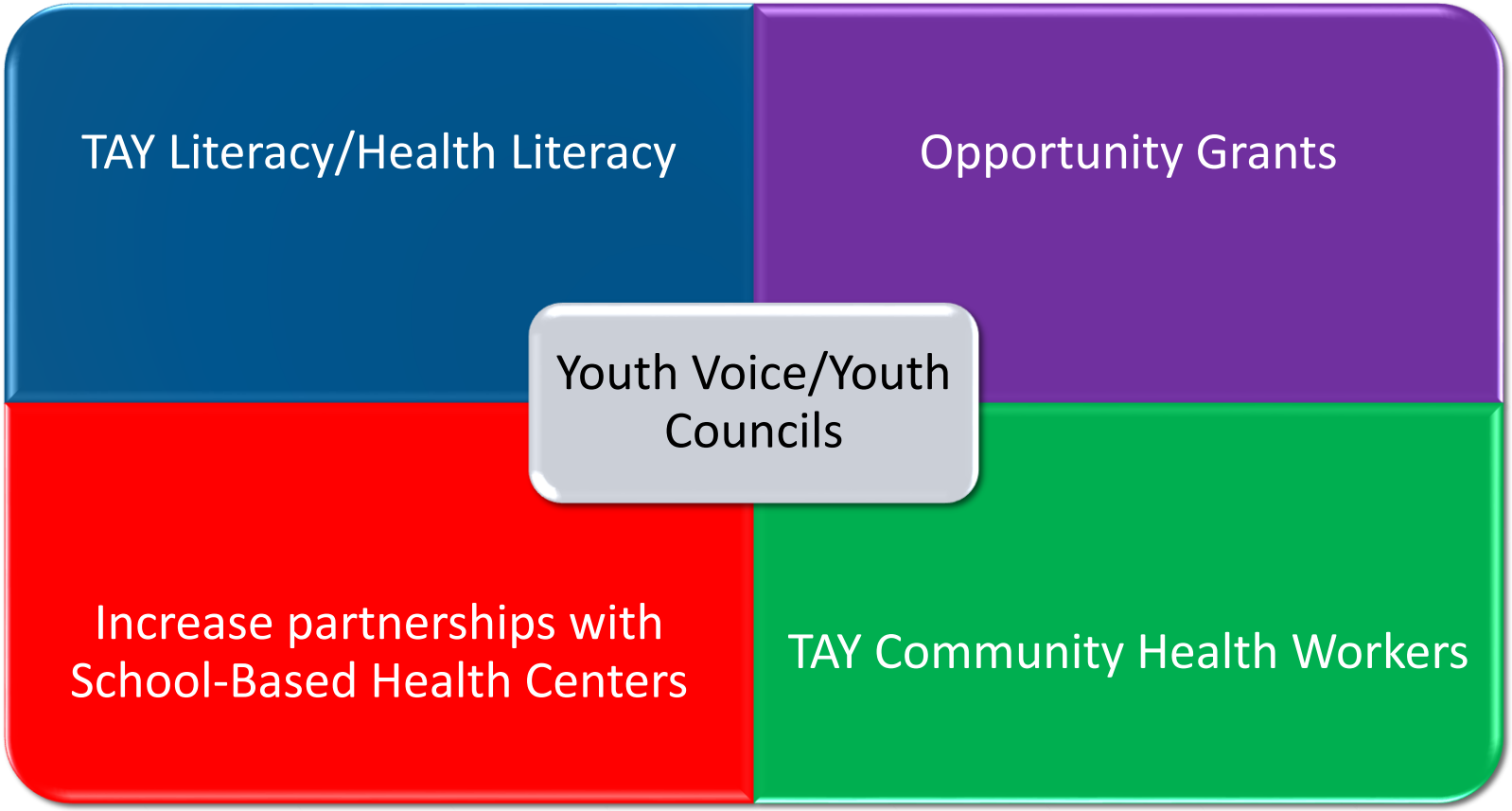
Increase support of youth as they transition from youth to adult systems especially as in the areas of exiting foster care and accessing mental health services

Increase in TAY voice utilization to drive strategy and service development and assessment

The Process


Baseline Data
• Survey
• Listening sessions
• FC Metrics (Who we serve, how we serve them)
Establish Priorities for youth success
• Analyze data
• Gap analysis
• Align efforts that exist with priorities/efforts
• Develop bridge for gaps where needed
Run the Play
• Implement identified strategies

Strategy Buckets



Healthy Columbia Willamette Collaborative

- Includes 15 hospitals, four health departments and two CCOs in Clackamas, Multnomah, Washington and Clark Counties

- Currently conducting a community health survey
  - Please spread the word among your communities!
  - We need more male and low income respondents!
  - Survey available online at www.healthycolumbiawillamette.org
  - Paper surveys are also available. Please contact Genevieve Ellis at genevieve.ellis@multco.us.
  - *See handout for additional information*

- Survey findings will inform Community Health Needs Assessment and impact subsequent health improvement plans/activities