health share

Health Share of Oregon

Housing with Services

History

Leading Age Oregon Leadership Academy sparked me to embark on a project that not only touched my direct reports, but also the Ministry as a whole. I got my project idea at the Fall Leadership Conference in October 2012 after listening to a presentation on Long Term Care 3.0 (LTC 3.0).

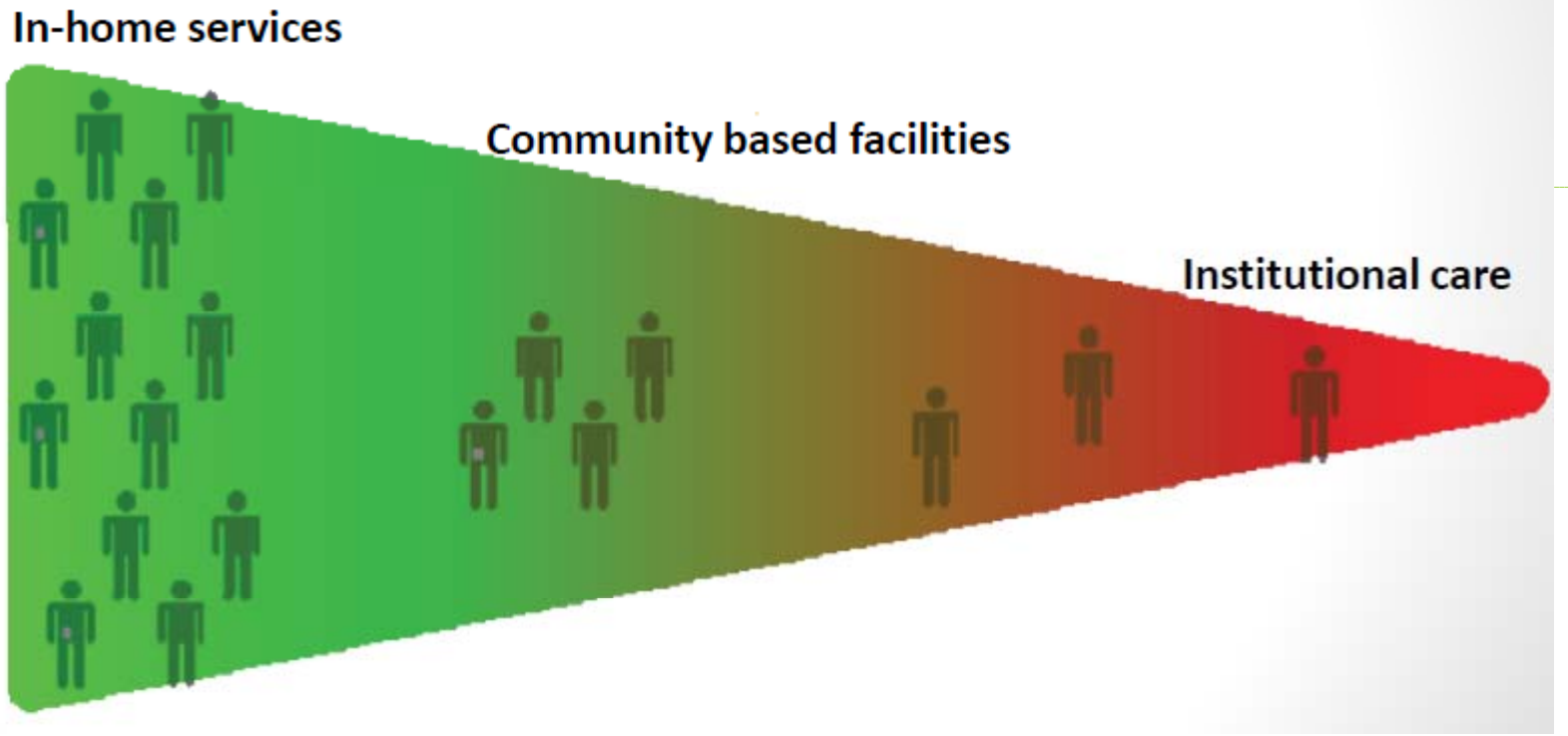
Purpose:

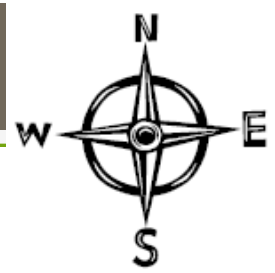
To be in line with LTC 3.0 the future is moving toward more specific goals of Community Care which focuses on settings such as ACH and care in the home (individual's home, retirement home, etc.). This is something that ElderPlace has been doing for more than 20 years, however one of my sites primary areas of focus is in our own ALF. In order to be cutting edge I decided to look at how I could partner with a retirement home or group of retirement homes or HUD buildings to provide medical care/management in the residents home/community setting while also working to increase the overall census in our ministry by touching the lives of more residents in community environments.

SMART Goal:

To create a Medical Model centralized in Retirement Community to allow for direct health care/management in their own home. We would provide the PACE Model onsite one to two days a week. (The thought would be to have this be part of the existing Pace at Home Panel in existence at Irvington Village. All health plan functions and quality oversight will be done through our existing systems.

The Continuum of Care





Smaller Project:

Refine the current Resident Care Navigator Role to make sure the position was being optimized.

Goals:

- **Create better self driven health experiences for the non ElderPlace residents in the building; both with services and without while still encouraging maximum independence.**
- **Reduce health care disparities base on race, ethnicity, socioeconomic status, etc.**
- **Seek out innovative and transformational approaches to care**
- **Promote Peer support and Community involvement**
- **Manage chronic health conditions**
- **Reduce costs and reduce hospitalizations**

Smaller Project: (Continued)

Outcomes:

- Identified and maintained relationships with referral partners for many health care and health well being partners such as foot care, home health agencies, Mental Health Partners, transportation, shopping, Store to Door, etc. just to name a few.
- Set up sustainable community partnerships and peer support relationships.
- Completed a baseline survey of residents needs to include social needs and then will monitor the success of the program and services on behalf of the residents.
- Held/Participated in many community events to include some such as IRV Breast Health Awareness Health Fair, Participated in three Harsh Properties Health Fairs, Community BBQs, and Friends and Family dinner.
- Connected Resident Services Navigator with Harsh Properties Resident Services Coordinator to gain more knowledge and networking.

Larger Project:

Partner with Cedar Sinai on a Housing with Services project that is due to go live 2014 which will impact the lives initially of about 2000 Oregonians. One of the overall goals of the project is to eventually be able to replicate it all across Oregon and other states as well.

Stake Holders:

Residents of 4 Harsh Properties and 4 Home Forward Buildings, Cedar Sinai Park (CSP), Providence ElderPlace Care Oregon, Home Forward, Cascadia Behavioral Health, Jewish Family & Child Services, Asian Health and Service Center, Sinai Family Home Services, Lifeworks Northwest, DHS, CMS, Outside In, Multnomah County Department of Aging and Disability Services

Larger Project:

Goals:

- Improve health outcomes for underserved populations
- Decrease utilization of hospital care, emergency rooms and involvement with the Criminal Justice Department
- Delay entry into Long Term Care
- Facilitate care transitions that improve health and prevent reinstitutionizing.
- Create a culture of wellness through a focus on social determinants of health including increased community engagement, improved access to culturally specific and effective services and preventative health care.
- Establish a successful collaboration among partner agencies and with Coordinated Care Organizations
- Create financial sustainability, measurable cost savings and replication

Project to date:

- CMS has provided a grant of $440,000 towards this project for planning and project evaluation
- CSP has received other generous grants toward the project
- Residents needs surveys have been completed and reviewed
- Home Forward has committed to involve 4 of their buildings in the project
- Providers and Partners are working out the LLC or MOU agreements
- Housing with Services Planning Group with resident attendees have worked to build an initial service integration package
- Broke ground at the 1200 building where the Medical/Social Center will be
- Consortium Work Group continues to meet
- Medical supplies and equipment needs finalized and ordered
- Housing with Services Demo project will launch early 2014

Conclusion:

"Approximately 38% of older subsidized housing tenants live in their apartment until death, but 25% of them leave for a nursing home. In 2004, a year-long stay in a nursing home funded by Medicaid cost an average of $49,000, while a HUD Section 202 unit, plus the most frequently provided services (food, transportation and housekeeping) cost $13,000." (Carder, Paula C, 2012) This quote rings true that community based care is not only resident choice, but also cost effective. So I challenge you to also look toward the future and work on a project where you care provide the right services at the right time and in the right place for the elderly. It just takes one bold and innovative strategy to set the course for success for our seniors.

This project really helped me to stay in line with the Providence Mission statement "As people of Providence we reveal God's love for all, especially the poor and vulnerable through our compassionate service". It also allowed me the freedom to continue to be cutting edge with health care always one step ahead to provide quality care to the members of the community that I serve. It renewed my belief in the old cliché; "If you build it they will come". If you put your mind to it you may find that others have the same idea or if you model the way, inspire a shared vision, challenge the process, enable others to act, and encourage the heart others will want to come.