CASE STUDY

Activate Care

OHSU OREGON HEALTH & SCIENCE UNIVERSITY

Oregon Center for Children and Youth with Special Health Needs

FROM CHALLENGES TO TRIUMPH

Care coordination is an essential component of state efforts to transform healthcare systems and improve value and outcomes. When successfully implemented, it can improve care quality, reduce costs, and avoid fragmented and duplicative care, especially among children and youth with special health care needs (CYSHCN). Care coordination has also been shown to improve health care utilization and family functioning and satisfaction, and reduce families' financial burden and unmet needs for services.

In the state of Oregon, one in five children under age 18 has a special health care need, and 44% of these children have a condition that affects their daily activities. They require health and related services of a type or amount beyond that required by children generally. Based at Doernbecher Children's Hospital at Oregon Health & Sciences University, the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) is Oregon's public health agency designated to help these children and their families navigate care.

OCCYSHN coordinates efforts among county public health departments in Oregon and 90+ partners across the state. In their care coordination model, public health nurses employed by counties visit families in their homes to assess needs and collect information in the pursuit of care coordination. Activate Care equips these nurses with electronic shared plans of care to track a child's health information, continuously coordinate care amongst families and care team members in the community, and maintain real-time, actionable care plans, accessible to all members of the care team, including parents and families.

Children enrolled in Medicaid who receive OCCYSHN's care coordination services are:

- 13% less likely to visit the emergency room.
- Twice as likely to receive annual flu immunizations.
- 28% more likely to complete annual well child care visits.
- 21% more likely to complete annual dental care visits.

COMMUNITY HEALTH OUTCOMES THAT LAST

"We needed wraparound services for my grandbaby. Referrals were getting dropped. Healthcare providers weren't talking to each other. I didn't know what was going on. It seemed like nobody wanted to help.

When I got Activate Care, I got to add everybody I wanted to be in my support group. My Home Visiting Program Manager brought in her care team. We had our first meeting with everybody together, and they pulled up my grandson's information on the screen.

I was waiting for everybody in the room to hit me with a load of questions, and make me go back to the beginning. But I didn't have to do that. They all had everything they needed right in Activate Care.

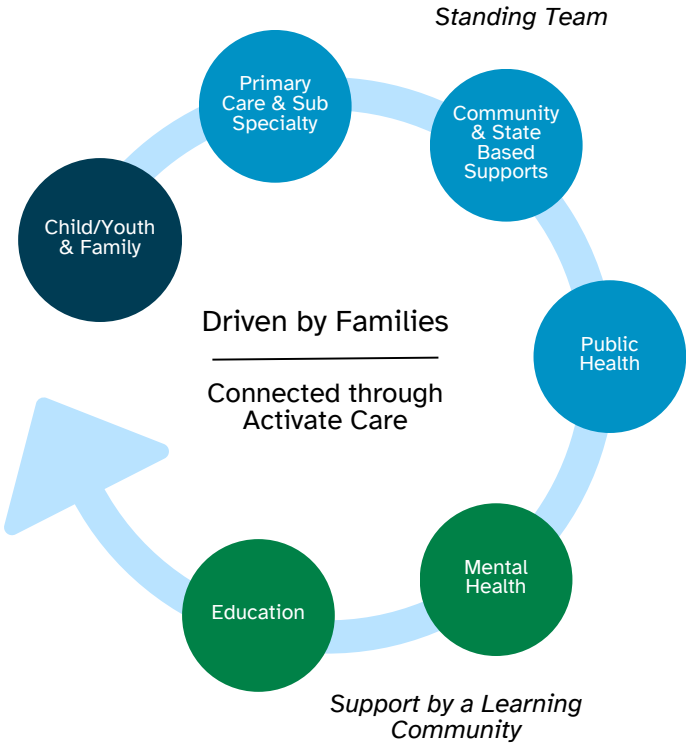
No more pre-doctor's appointments to explain things in advance of a doctor's appointment. No more running around. The care team had the tools they needed to do their work, they could understand what was needed, and they could manage the referrals as a team.

The mobile website is a piece of cake. The other day we were having problems with my grandson's liquid nutrition. I sent a message to the team on the app. Within a half hour, they messaged me back. Then I got a call from the nutrition provider saying food was on the way.

If I'm in a crisis with my grandson, I send a message in Activate Care and the team is on it - immediately. I've never waited more than 24 hours for any response and I always see the outcome of that response. It is nothing like the patient portal. It's so much more.

I really recommend this. If you think about how much time it frees up for our doctors, how much money it saves, how easy it makes things for everybody... Within a week of getting Activate Care, my life had changed for the positive."

Tamra, Grandmom of Rady, Age 3 | January 2020
Names Changed to Protect Privacy



All-in-One Platform for SDOH Care

CareLink is a complete solution for effective community care management. Our platform efficiently streamlines client care with a single view into services, programs, and referrals. Each client has an individual community care record to track, monitor, report, and, with client permission, share outcomes.

Our closed-loop referral system enables seamless coordination and tracking of bidirectional referrals across the community, enhancing communication and shared decision-making and fostering mutual trust in community health programs. Through workflow automation, team-based tasks and goals, non-medical billing, and integrations, CareLink makes facilitating care easy so you can focus on what matters.

Activate Care

For more information about how Activate Care's CareLink Platform can support your organization, visit activatecare.com.