OHSU Transitional Care Programs

C-Train:

- 3 nurses and 1 clinical social worker
- Staff meet with patients while admitted at OHSU and assess for areas of need
- Provide 30- to 90- day transitional care that supports underserved patients at OHSU by bridging gaps in post-hospital care

New Directions:

- 4 clinical social workers
- Provide care coordination support for adults 18 and over experiencing houselessness who are marginalized, underserved, uncoordinated, high risk populations with high-cost utilization within the Tri-County area
- Must currently be accessing care at OHSU
- Target individuals with high ED utilization and repeat inpatient hospitalization
- At least 5 ED visits in 12 months or 3 ED visits in 2 months
- Work to impact the effects of health inequities for historically marginalized groups by collaborating across the healthcare continuum to ensure the appropriate level and depth of care
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Transitional Housing Program:

- Program includes .6FTE LCSW and 1.0 SWS
- Focus on medically and psychosocially vulnerable patients who experience delays to hospital discharge due to lack of safe, sanitary settings in which to recuperate.
- THP works closely with inpatient providers and partner with inpatient social workers to identify post-discharge housing plans for patients and offer hotel or independent living placement to bridge to those plans.
- Patients can stay in transitional housing for up to 90-days and must engage at minimum in weekly visits and weekly phone calls from social work staff and follow up care.

Collaborative Advocacy Through Community Healthcare (CATCH) Program

- Nurse Practitioner acts in a pre-primary care position until the client is engaged with a longer-term medical home, and oversees care coordination/management provided by nurses, faculty, and licensed Social Workers (LCSW).

Goals/Objectives:

- Reduce EMA calls, ED visits, and hospitalizations.
- Improve self-sufficiency through care coordination.
- Operationalize a system for billing and cost recovery of CATCH services.
- Minimize redundancy in care improved collaboration between multidiscipline / improve handoff so patients are moving through the continuum.

HCV Transitions to Treatment (TOT) Pilot Program

- **Program Concept**: pilot designed to address critical social inequities and healthcare barriers for people who use drugs (PWUD) and are chronically infected with hepatitis C virus (HCV)
- **Aims:**
    - Identify hospitalized patients with substance use disorder infected with HCV who have been unsuccessful in accessing treatment using standard referral pathways
    - Pair them to HCV TOT coordinator, who performs a comprehensive assessment of social determinants of health and readiness for, and barriers to, treatment
    - Coordinate completion of necessary laboratory and imaging investigations with the primary inpatient team
    - Provide education on HCV including how it is acquired, how to reduce transmission risk, and complications of untreated infection
    - Provide resources to complete a virtual HCV treatment consultation at discharge
    - Follow treatment course for adherence
    - Monitor for sustained virologic response at 12 weeks post treatment completion