Waterfall CHC:
Social Determinants of Health Efforts

About *Waterfall*

Who We Are:
Our mission is to promote access to quality integrated health services that meet the needs of individuals with barriers to care on the Southern Oregon Coast.

Who We Serve:
- 4100+ patients served

Services Provided:
Primary Care, Mental Health, Integrated Behavioral Health, SBHC, Social Health, Women's Health, on site 340b Pharmacy

Quick Facts:
-1300 individuals who are homeless (2018 PIT Count)
-19.9% of Coos County residents live under the FPL
National average is 13.4%
-7,258 veterans live in Coos County

Social Needs Screening Goals

Achieving health equity requires addressing the social, economic, and environmental factors that influence health and wellbeing. These factors are referred to as the social determinants of health. Waterfall Community Health Center is actively working to better understand and address the social determinants of health that impact our patients and our communities.

SDH Screening for all Waterfall Patients began January 2019
- Universal screening of all 4100+ patients
  Includes patients with only Mental Health or Women's Health Provider
- Modified PRAPARE Screening Tool; collecting data on all 9 selected SDH
- Identifying which SD present the most significant barriers for our patients

Screening Data Collection Methods

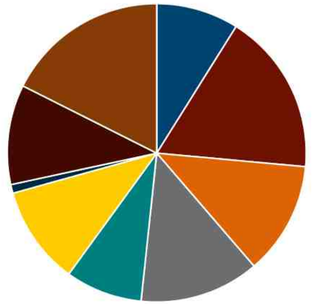
Screening Tool and Technology Used: *EPIC OCHIN EMR*

Waterfall uses PRAPARE, a national screening tool and approach to collect standardized social needs data to better understand patients' social needs. PRAPARE was informed by research, the experience of existing social risk assessments, and stakeholder engagement.

Methods and Measures
- Multi-method approach to capture screenings
  Survey prior to office visit is most successful method
- 58% of active patients screened (As of October 31, 2019)
  [Total # patients screen for 1+ SDs/Patients with appointment in last 12 months]
- EPIC icons indicate screening results
  Green icon indicates no need, **yellow** need, and **grey** lack of data

Findings

Quantitative Outcomes



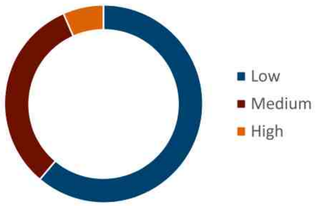
According to PRAPARE screening results, the most common social risks for our patients are:

1. Physical Activity
62% of patients
2. Financial Strain
62% of patients
3. Housing
46% of patients

Measuring risk to determine follow up procedure:

- Low risk, 0-3 barriers, no follow up unless requested
- Med risk, 4-6 barriers, follow up at next appointment
- High risk, 7-9 barriers, immediate follow up

*Any patient scoring relationship safety risk is an *immediate* follow up regardless of score*



Qualitative Findings

Waterfall's Equitable Patient Outcome Study (WEPOS)
- In partnership with OHSU Campus for Rural Health
- Gathered unbiased feedback about how Waterfall can break down top SDH barriers

Held patient cafés and asked:
1. Tell us more about how [barrier] is affecting you.
2. What is already helping to alleviate [barrier] in our community?
3. What else can we do to help break down [barrier]?
   "Magic wand ideas."-Equity in mind

Physical Activity
"You can only walk at Mingus Park so many times."

Financial Strain/Employment:
"Money is a constant issue, not an occasional one."
"There just aren't jobs anymore for lay people with only a high school education."

Housing:
"I would rather be homeless than deal with the headache of housing."

Food Insecurity:
"The food banks are only open when I'm working."
"Food is only helpful if there's somewhere to cook it."

Health Center Response to Social Needs

Addressing SDH takes staff time, resources, and space to ensure it is done thoughtfully.

Health Center Interventions
- CHC Restructuring:
  - Hired 4 certified Traditional Health Workers
  - Integrate into patient care teams
  - Clinic-wide dissemination of SDH data
- Define the scope of social health patient care at Waterfall

Community Partnerships
- Bay Area Hospital grant for transportation & food assistance programming
- Medication assistance donation provided by Walmart Pharmacy
- WEPOS in collaboration with OHSU campus for Rural Health
- Advisory role in Coos County Community Health Improvement Plan (CHIP)
- Oral Health Screenings provided by Advantage Dental

Veggie Rx and on site "Farmacy" in partnership with South Coast Food Share
***Supported by Advanced Health**

Patient Impact Feedback:
"I eat breakfast more often now. I like eating zucchini with my eggs."
"We don't have a way to cook anything. The fruit is so helpful!"
"This really helps me, living on SSI doesn't allow for any extra spending on produce."
"My family and I are eating healthier. My daughter loves the fruit!"

Next Steps

Next Steps
- Follow up and case management for >60% of patients with barriers
- WEPOS Next Steps
  - Nutrition education components to Veggie Rx program
  - Physical activity programs in partnership with Walk With Ease
  - Transportation programs
  - Connect non-Medicaid patients with critical resources
- Strategizing on affordable dental care for Medicare and uninsured patients
- Patient stress management
- Reduction in patient social isolation

Contact Information

The healthcare environment is rapidly changing in recognition of the importance factors such as a person's home, job, and/or education play in improving health outcomes. We know these social factors are critical for many of our patients and strive to better understand the role of social context for each patient's treatment plan, but also to advocate for needed systems change to achieve better population health.

For opportunities for partnership, please reach out to our team at: (541) 435-7014

PRAPARE *This poster was modified from PRAPARE's Show & Tell template*