Community Health Centers of Lane County: Social Determinants of Health Efforts

About *Community Health Centers of Lane County*

Who We Are:

The mission of the Community Health Centers of Lane County is to improve the health can wellness of our community through access to affordable, holistic healthcare.

Who We Serve:

- *We provided more than 115,000 services to just under 30,000 patients in 2018.*
- *Services are provided in 6 Eugene/Springfield area clinics. We also provide preventative dental services in schools throughout Lane County.*

Services Provided:

Our services include primary care services for patients of all ages. We also provide prenatal care, integrated behavioral health, alternative care, and preventive dental services.

Social Needs Screening Goals

It is increasingly recognized that improving health and 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. Our health center is actively working to better understand and address the social determinants of health that impact our patients and our communities.

Our goal at LCH&HS is to make lane county the best place to live, work, and play. An important aspect of that is health equity. Collecting SDoH data is key in determining where our gaps are in order to focus our limited resources in areas where our community members are most vulnerable.

- *Our target population at this time are patients at our CHC clinics. Currently we have rolled this to 4/6 clinics*
- *We are utilizing a PDSA model in order to make rapid changes as we rolled this out to each of our 6 FQHC clinics and then across our Health & Human Services department.*
- *PRAPARE is the tools we are utilizing*

Screening Data Collection Methods

Screening Tool and Technology Used

Lane County uses PRAPARE, a national screening tool and approach to collect standardized social needs data to better understand the patients' social needs. PRAPARE consists of a set of core measures as well as a set of optional measures for community priorities. It was informed by research, the experience of existing social risk assessments, and stakeholder engagement.

Methods and Measures

- *Our collection method has been primarily through the paper tool. After several trials we have our OA's passing it out to each patient when they arrive at the front desk for check in. We are transition to a kiosk over the next several months and will give the option to either utilize the kiosk or the paper form*
- 58% of CHC patients seen *(1+ non-UDS domains)* in the last year were screened, 12.93% of CHC patients seen in last three months were screened using full PRAPARE.
  - *Numerator: Distinct active patients screened for any 1 or more non-IDS SDH question in PRAPARE in the last 12 months (rolling calendar)*
  - *Denominator: Distinct active patients with a visit in the last 12 months (including children)*
- Over 94% of patients offered the PRAPARE screening tool in the last month completed it.

Resources

This implementation was done with no additional funding. We did have some staff time dedicated for the supervisor, quality coordinator, and management analyst to introduce the tool and workflow, support staff implementation, and analyze the data collected. Additionally we made multiple adjustments to a custom created template in Next Gen, our EHR. We also utilized Tableau to visualize our results and allow staff to interact with different data points.

Findings

PRAPARE - Needs Methodology:

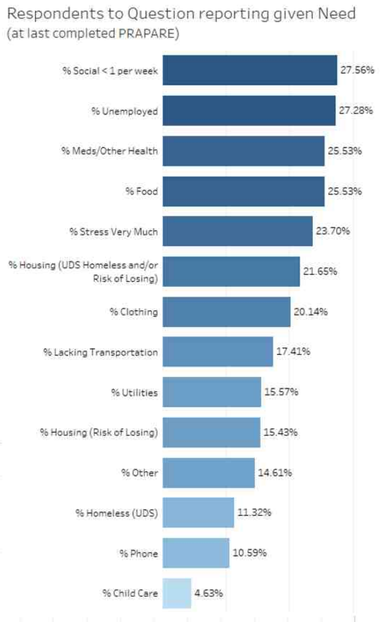
The needs proportion were calculated by utilizing the unique patients/clients who responded to the question as a need divided by the unique patients/clients who responded with a yes or no to the question. Those who refused the question or didn't answer were not included in the proportion of needs.

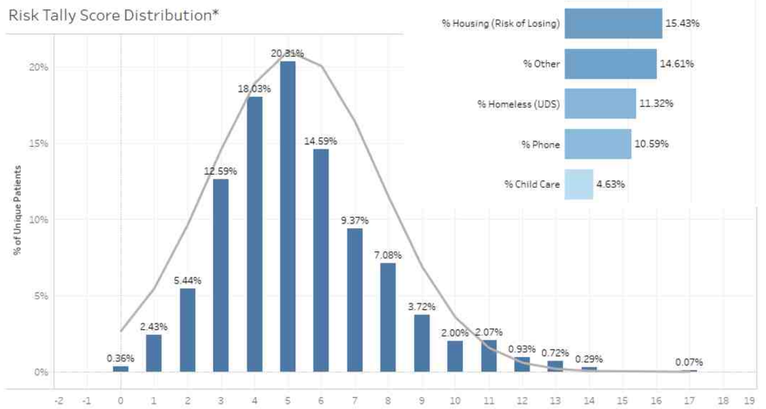
Risk Tally Analysis:

The needs and risk tally were calculated utilizing the NACHC PRAPARE Risk Tally Scoring Methodology as shown at http://www.nachc.org/wp-content/uploads/2019/01/PRAPARE-SDH-Risk-Tally-Score-Methodology.pdf.

Only the most recent completed PRAPARE questionnaire for each patient/client is considered for the tally calculation.

*Note: The Normal Distribution is based off an estimate.





Qualitative Findings

Within several days of beginning this project we had a patient come in for an appointment. He was a young man, in his early twenties, and severely underweight. He was living in his car after moving up from California to begin a new job. When he arrived he learned there was no longer a job waiting for him. He had used all his resources to get here, and being new to the area he had no friends or family in the area. He was also unfamiliar with available services and resources. When he arrived at the clinic for his appointment our team was immediately very concerned for him. After completing the PRAPARE questionnaire it became apparent how dire his situation was. Fortunately, Sandi, who was implementing the survey at this clinic, was familiar with Dovetail, a program within our department that 'advances internal communication and coordination across the divisions, focusing on people with complex and intensive needs to ensure they are connected to the most personally beneficial programs and services.' Dovetail had open office hours that day and Sandi walked this patient up to the office personally, where they were immediately able to meet with the individual. To have the ability to see a new patient in one of their worst moments and be able to offer not only medical attention and compassion, but also a warm handoff to another person with immediate resources feels really good. That is the power of PRAPARE at its best.

Health Center Response to Social Needs

Understanding patient's social needs is at the foundation of the health center movement. That began in the 1960s War Against Poverty. Since then health centers have strived to improve whole-person care beyond the medical visit. Yet this work takes staff time, resources, and space to ensure it is done thoughtfully.

Health Center Interventions

- *We have implemented a nationally recognized screening tool to provide quantifiable, reliable data on the social needs of our patients. We have conducted more than 22,600 screenings this year.*
- *Our Trauma Informed Care Committee has developed training tools for staff to improve patient-staff engagement.*
- *We have implemented a new program, (Dovetail), within Health & Human Services to coordinate and integrate care for the highest needs individuals. This care coordination team has used health navigators to connect individuals with an array of wrap-around services, most notably with housing assistance, and social supports.*
- *We have significantly increased our health and wellness outreach calls to patients – providing more than 24,000 phone calls through November of this year.*
- *We have implemented a patient experience group to help prioritize service offerings and improve patient engagement.*

Community Partnerships

- *We have expanded and strengthened health partnerships with agencies throughout the community.*
- *We have collaborated with Food for Lane County to provide food distribution at all of our clinics.*
- *Our staff have participated with United Way and community partners in the developing the Community Health Assessment to better prioritize the needs of our community.*
- *We coordinate services with other key safety net clinics including White Bird Clinic, and Volunteers in Medicine.*

Lane County Human Services

United Way of Lane County

FOOD For Lane County

Next Steps

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- *We are continuing to train staff to roll out the PRAPARE questionnaire across all 6 CHC clinics, and to begin making changes based on data; e.g. increased food and transportation options.*
- *We will review the needs data with our patient experience groups and health advisory council.*
- *We would like to expand this project from the FQHC sites to all of the Health & Human Services divisions as well as adapt this to begin including pediatric patients and their families as well.*

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: *Ron Hjelm, Community Health Centers of Lane County Manager*