SouthRiver Community Health Center: Social Determinants of Health Efforts

Efforts to improve health across the country have often looked to clinical settings and health care as the key driver of health and health outcomes. Increasingly, it is recognized that improving health and achieving health equity will require approaches beyond medical attention that move upstream to address social, economic, and environmental factors that influence health. Our health center is actively working to better understand and address the social determinants of health that impact our patients and our communities.

ABOUT US

SouthRiver Community Health Center was established in 2006, and became a federally qualified health center in 2012. SouthRiver now operates as a Patient-Centered Primary Care Home, providing integrated physical and behavioral health services. We are committed to providing timely and affordable care for residents in the Winston, Roseburg and surrounding communities. We operate three fully-integrated primary care and behavioral health clinics in Winston and Roseburg. We serve over 4,000 patients annually, with the goal of providing access to the highest quality care to our community, regardless of ability to pay. Our mission is to provide our communities access to world class primary care, addictions treatment, behavioral health care and prevention services to promote health and restore lives.

SCREENING FOR SOCIAL NEEDS

SouthRiver Community Health Center uses PRAPARE, a national screening tool and approach to collect standardized social needs data to better understand the patients’ social needs and transform their care. PRAPARE consists of a set of national 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. It aligns with national initiatives prioritizing social determinants (e.g., Healthy People 2020), measures proposed under the next stage of Meaningful Use, clinical coding under ICD-10, and health centers’ Uniform Data System (UDS). For more information on PRAPARE, visit www.nachc.org/prapare

In 2019 we began using PRAPARE with patients receiving behavioral medicine services. If a need is identified through the screening, a case manager will follow-up with the patient in person or by phone to connect the patient with available resources. Our goal is to implement PRAPARE screening clinic wide in 2020. We hope to be able to do this electronically through the patient portal. Our case manager availability is limited, so we are currently developing a resource manual so that the team-based patient care coordinators will have the knowledge to help connect patients with appropriate resources. Patients who need ongoing case management as identified by PRAPARE can be referred to a case manager.

UNDERSTANDING OUR PATIENTS’ SOCIAL NEEDS

Based on our screening efforts using the PRAPARE tool, we have found that the most common social risks for our patients are:

1. Unemployment 62% of patients surveyed
2. Lack Transportation 24% of patients surveyed
3. Food Insecurity 16% of patients surveyed (23% did not answer)
4. Limited Socialization 16% of patients surveyed
UNDERSTANDING OUR PATIENTS’ SOCIAL NEEDS

Social Needs for Patients with Depression

<table>
<thead>
<tr>
<th>Social Needs</th>
<th>Patients w/ Score ≥5 on PHQ-9 (depression)</th>
<th>Patients w/ Score &lt;5 on PHQ-9 (no or minimal depression)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployed</td>
<td>66%</td>
<td>51%</td>
</tr>
<tr>
<td>Lack Transportation</td>
<td>24%</td>
<td>7%</td>
</tr>
<tr>
<td>Food Insecurity</td>
<td>16%</td>
<td>12%</td>
</tr>
<tr>
<td>Socialize less than once per week</td>
<td>16%</td>
<td>15%</td>
</tr>
</tbody>
</table>

HOW OUR HEALTH CENTER IS RESPONDING TO PATIENT’S SOCIAL NEEDS

Our biggest goal with implementing screening is to be able to connect patients with needed supports and actively address SDoH. To that end, we have developed a number of community partnerships, as well as building resources within our clinic, to help meet these needs. At SRCHC, we have planted a community garden, created a clothing donation and distribution system, provided bus passes, participated in Veggie Rx targeting food insecurity, and have a co-located advocate from Battered Person’s Advocacy. We also actively with other local agencies. Community partners include BPA, UCAN, DHS, Umpqua Neighborworks, the Dream Center, local food pantries and shelters, and senior centers. We have a passionate case manager who goes above and beyond to, sometimes creatively, meet the needs that PRAPARE screening helps us identify.

WHY WE BELIEVE IN THIS WORK

It always comes back to the patients and there are so many amazing stories. In one instance, an elderly patient was months behind on her electric bill. Because she did not volunteer this information, it was not until she completed the screening that we were able to identify this need. Our case manager connected her with UCAN, who paid the entire bill, preventing this patient from having her electricity cut off. In another case, we identified a young mother who needed diapers and medication for her two children. We were able to connect her with resources available through DHS, allowing her to have ongoing support in caring for her children. There are so many more stories that illustrate how SDoH screening allows us to meet our patients’ needs and improve their health.

Understanding patient’s social needs is at the foundation of the health center movement. Community health centers came out of the War on Poverty in the 1960’s and since then, have strived to provide whole person care by creating space to discuss and address needs well beyond the medical visit. Yet this work takes staff time, resources, and space to ensure it is done thoughtfully. That’s why SRCHC is proud to share in this work and consider opportunities for alignment.

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