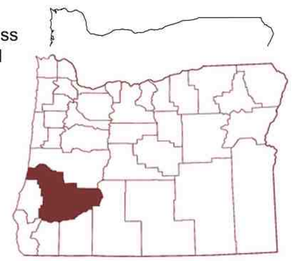
SouthRiver Community Health Center:
Social Determinants of Health Efforts

About SRCHC

Who We Are:
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.

Who We Serve:
In 2018, we served over 4,000 patients in Roseburg, Winston, and surrounding communities, including rural Douglas county



Services Provided:
Medical, behavioral health, MAT, coordination with local substance use and mental health services

Quick Facts:
SouthRiver was awarded a HRSA 2019 National Quality Leader Award for Behavioral Health

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.

We began using PRAPARE with patients receiving behavioral medicine services. As our data shows, this is an especially vulnerable, high needs population. This is also a group of patients with the most direct access to our case manager, who was the individual piloting the implementation of PRAPARE. We hoped to get a better sense of gaps in care where we could better meet the needs of this population of patients.

Screening Data Collection Methods

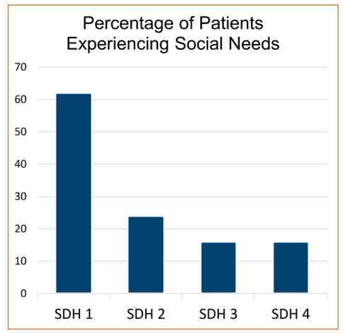
Screening Tool and Technology Used
SRCHC uses PRAPARE, a national screening tool and approach to collect standardized social needs data to better understand the patients' social needs. PRAPARE consists of a set of core measures as well as a set of optional measures for community priorities. It was informed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

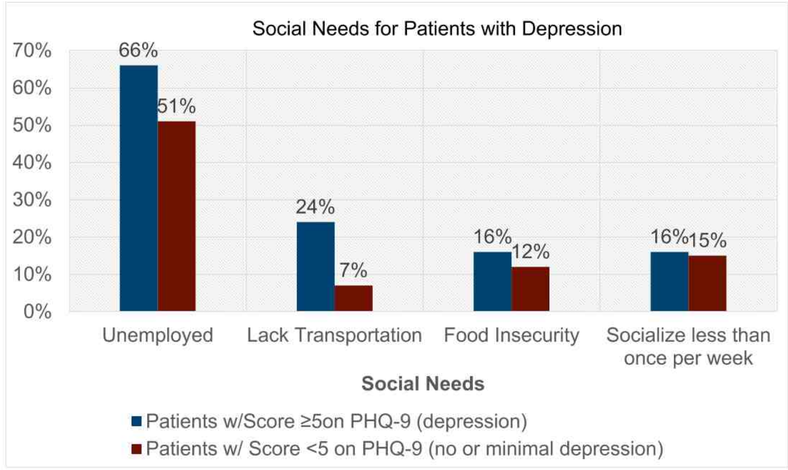
Methods and Measures
- We focused on screening patients engaged in behavioral health services
- Began screening in June 2019
- 331 unduplicated patients have been screened (7% of total patients seen)
- Patients are also administered the PHQ-9 in conjunction with their office visit with a behavioral health clinician

Findings

Quantitative Outcomes
Based on our screening efforts using a social needs screener, 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





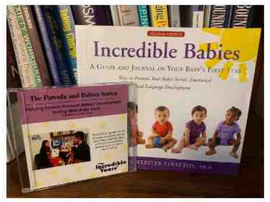
Qualitative Findings

Patient Stories:
- An elderly patient was months behind on her electric bill. We were able to identify this need with PRAPARE. Our case manager connected her with UCAN, who paid the entire bill, preventing this patient from having her electricity cut off.
- PRAPARE helped us identify a young mother who needed diapers and medication for her two children. We connected her with resources available through DHS, which also provided ongoing support in caring for her children.

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 are taking more steps to address food insecurity through planting a community garden, participating in community programs such as Veggie Rx, and even beginning an emergency food pantry at our clinic
- We recently opened a donation based clothes closet for patients, as well
- We have learned that most patients prefer not to disclose financial information in this context, so as we expand PRAPARE screening, we will likely eliminate specific questions about income and focus on other needs.
- Regardless of what our priorities are, we have to meet patients where they are at and support them in their priorities
- We will soon begin parenting intervention and skills education and training in conjunction with Well Baby Visits to address SDoH early in life



Community Partnerships
- Referrals
  - We regularly refer patients to community partners to help address identified needs
  - Battered Persons Advocacy, UCAN, DHS, emergency shelters, Dial-a-Ride, Umpqua Neighborworks, Dream Center, food pantries, senior centers
- Partnerships
  - We have also developed key partnerships to offer even more integrated services
  - Onsite BPA advocate, Blue Zones for Veggie Rx

Next Steps

- One of our biggest struggles has been the limited resources available in the community, especially for housing. We plan to keep advocating for our patients and investing in our community to better meet the needs we see
- We plan to begin clinic wide PRAPARE screening in January 2020, utilizing our patient care coordinators to help connect patients with resources. We are currently developing a community resource manual to better equip our PCCs in this role
- We hope to use screening within the patient portal in order to seamlessly document the screening and related follow-up in the EMR.

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: Cora Hart, Behavioral Health Program Director, corah@srchc.org