**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)
- 18.9% of Coos County residents live under the FPL
- National average is 13.4%
- 7,275 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 SDH/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**
According to PRAPARE screening results, the most common social risks for our patients are:

- Physical Activity: 62% of patients
- Financial Strain: 62% of patients
- Housing: 46% of patients

**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 idea.” Equity in mind

**Physical Activity**
- “You can only walk it Mingus Park so many times.”

**Financial Strain/Employment**
- “Money is a constant issue, not an occasional one.”
  - “There just aren’t jobs anymore for low people with only a high school education.”

**Housing**
- “I would rather be homeless than deal with the hassle 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.”

**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

**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