Oregon's Community Health Centers:

Key Partners Addressing Social Determinants and Social Needs

Lunch plenary

Oregon Health Authority Innovations Café

June 5th, 2019

About the Oregon Primary Care Association (OPCA)

- OPCA is the statewide association of the 32 community health centers in Oregon.
- We provide technical assistance, training and policy support to health centers.
- We help health centers work together to advance the goals of health system transformation: better health, better care, lower costs, and health equity.

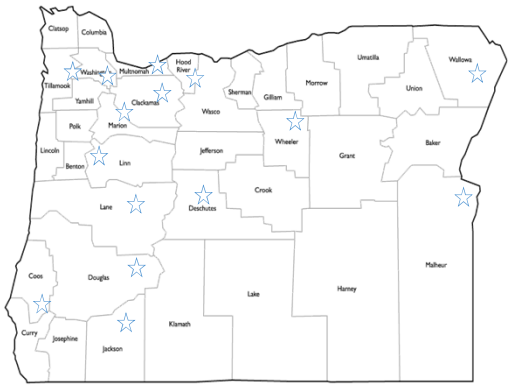
About Our Health Centers…

- Provide **primary care** to more than **433,000** patients
- See **1 in 10** Oregonians
- **Serve 1 in 4** patients on the **Oregon Health Plan**
- **5,500** providers and staff
- **1/3** of clinical locations considered **rural**
- **41% patients** identify as a **racial or ethnic minority**
- Integrate **medical, dental, behavioral health**, and **social care** models

Environmental Scan

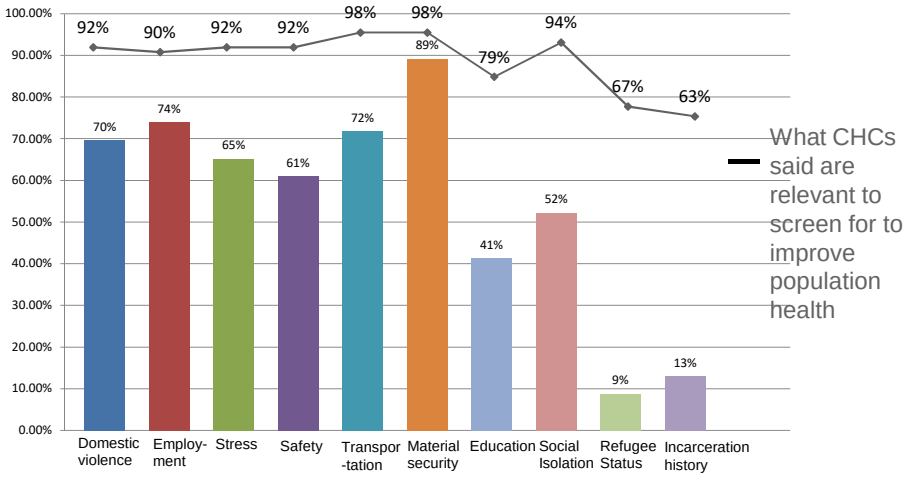
Key take-a-way:
Majority of respondents find it very important to understand and respond to patients' ***social issues.***

On a scale of 1-10 (10 being the most, important), **9** was the average rating selected.



Source: https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/sdoh-survey-results.pdf

CHCs Assess Patient Needs Broadly



Social Needs Programming at CHCs

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PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

New toolkit and translations in 10 new languages!

- Strengthens patient-care team member relationships and builds trust
- Helps develop targeted interventions, improve care coordination, and makes better use of partner/enabling services.
- Enables standardized social needs data collection for risk stratification and adjustment efforts at the payer and state levels.

For more PRAPARE information visit: http://www.nachc.org/research-and-data/prapare/

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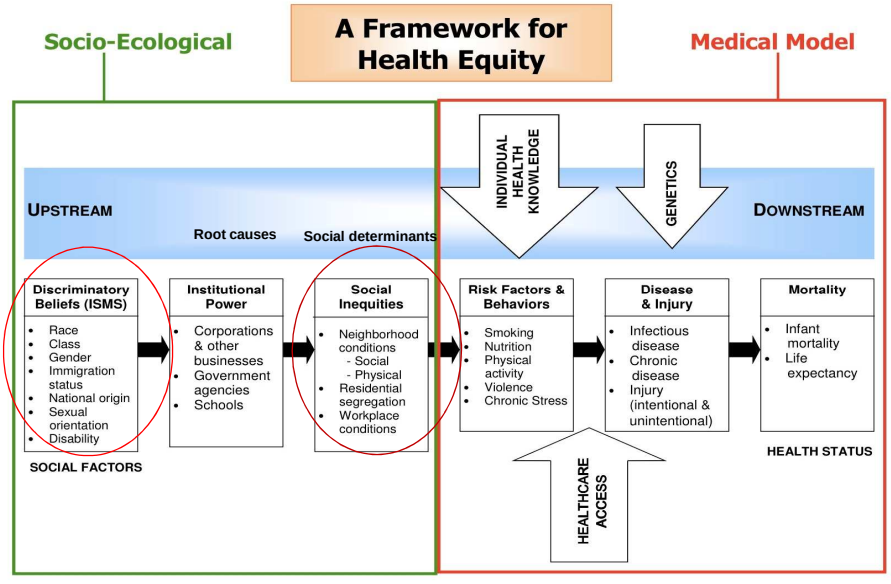
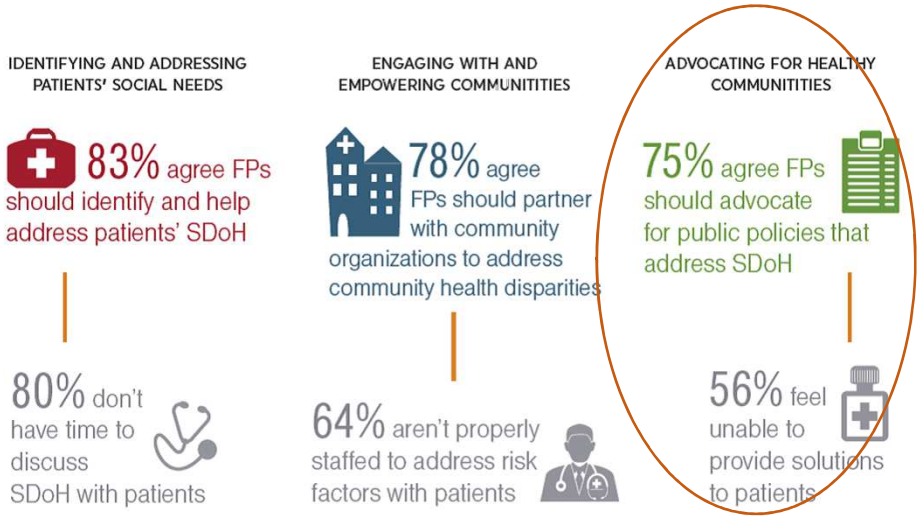
A Framework for Health Equity



Addressing Social Needs *and* Policy Change



Source: https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/sdoh-survey-results.pdf

Defining the Work

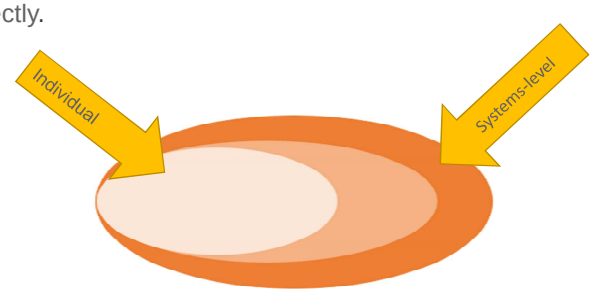
Social needs:

Informed care – using information provided on a patient's social context to inform treatment plan development.

Targeted care – using information provided to address patients' social needs directly.

Social determinants of health:

The conditions in which people are born, grow, live, work and age, which are shaped by the distribution of money, power and resources.



Adapted from: https://bit.ly/2M7ldJA

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Community partnership

Social needs AND social determinants of health

Scalability

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Panelists

Christine Mosbaugh MPH
Pop Health Manager, CHCs of Benton and Linn Counties

Charissa White MHA
Transformation Analyst, InterCommunity Health Network Coordinated Care Organization

Danell Boggs, LCSW
Behavioral Health Clinician, Tillamook County CHC

Brian Park, MD, MPH
Assistant Professor and Provider, Oregon Health & Science University (OHSU)

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Community Health Centers of Benton and Linn Counties

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Community Health Centers of Benton & Linn Counties

The CHC provides patient-centered primary medical care that focuses on the whole person. We understand how physical health, mental health and oral health all impact each other. We are committed to helping each person achieve their health goals and lead a happier, healthier life.

Corvallis Environmental Center

The CEC provides programming that makes Corvallis a healthier and more sustainable place to live. Every day we educate, engage and inspire our community to make that their mission too.

InterCommunity Health Network CCO

As IHN-CCO, we are committed to improving the health of our communities while lowering or containing the cost of care. We will accomplish this by coordinating health initiatives, seeking efficiencies through blending of services and infrastructure, and engaging all stakeholders to increase the quality, reliability, and availability of care.

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Corvallis Environmental Center

Community Health Centers of Benton & Linn Counties

Farm Stand- May to October

Local, organic produce for all!

Tuesday and Thursday
2:00- 4:30
Health Services Building, 530 NW 27th Street

Pilot supported by InterCommunity Health Network

We are screening patients for food security and providing tokens to increase access to healthy food at our stand and the Corvallis Farmers' Market. We are also interested in increasing access for staff, neighbors, and visitors at the Health Services Building to healthy, fresh produce. Please stop by and buy local, organic food to support the pilot, your health, and local food!

For more information contact christine.mosbaugh@co.benton.or.us, 541-766-6129

Community Health Centers of Benton & Linn Counties

Date: _____
MRN: _____
Name: _____

Health starts long before illness, in our homes, schools, and communities. Knowing more about these parts of your life helps us understand you better. **Today we are interested in knowing more about your access to food.**

Your care team will use your answers to the questions below to help you improve your health. All information shared with us is private and confidential.

In the last 12 months:

1. **I worried whether food would run out before I got money to buy more.**
   Often true Sometimes true Never true
2. **The food that I bought just didn't last and I didn't have money to get more.**
   Often true Sometimes true Never true
3. **I couldn't afford to eat balanced meals.**
   Often true Sometimes true Never true

Would you like more information about food resources in your community?
Yes No

If so, please share the best way to contact you (phone number, email, MyChart, mail)
_____

A Health Navigator will follow up with you to share additional resources.

For staff
Tokens provided? Yes No **Initials**_____

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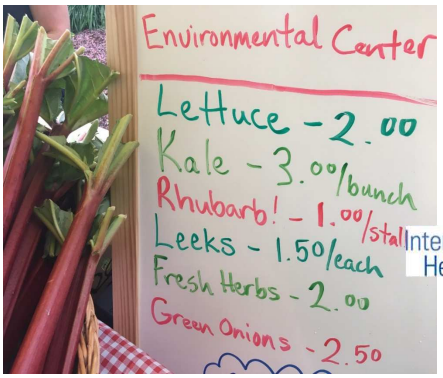
Community Health Centers of Benton & Linn Counties

Corvallis Environmental Center

Growth
Expansion
Sustainability



Activity	Expected Date(s)
Request for Proposal (RFP) Announcement	May 9, 2019
Question and Answer (Q&A) Session	May 20, 2019
Letter of Intent (LOI) Due – Required	**May 30, 2019 by 5:00 pm**
Invitations Issued to Submit Full Pilot Proposal	**By June 17, 2019**
Technical Assistance Meeting – Required	June 17, 2019 to July 18, 2019
Pilot Proposal Due	**July 22, 2019 by 8:00 am**
Pilot Presentations to the DST Committee	July 25, 2019 and August 8, 2019
DST Committee Decisions	August 22, 2019
Pilot Proposers Notified of DST Decision	By August 30, 2019
Regional Planning Council Funding Decisions	By September 5, 2019
Proposers Notified of Pilot Denial or Approval	**By September 13, 2019**
Transformation Department Creates Pilot Contracts	By November 1, 2019
Pilot Contracts Finalized	By November 30, 2019
Pilot Invoicing/Payments Begin	January 1, 2020
Although we do our best to adhere to this timeline, it is subject to change as circumstances occur.	

InterCommunity Health Network CCO

Transformation
CCO 2.0
Spreading best practices

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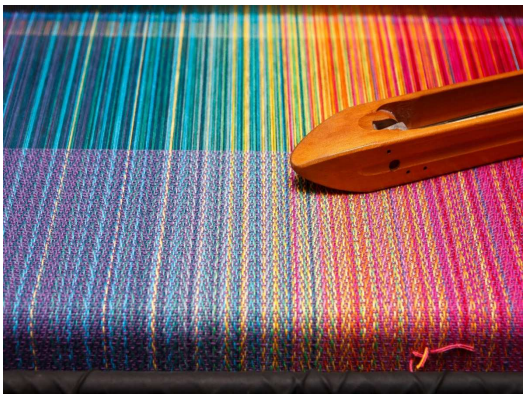
Key = Partnership

Leverage expertise

Collaborate for community benefit

Transform way we provide care



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18

Tillamook Health Center

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Intimate Partner Violence (IPV) Defined

One person in a relationship is using a pattern of methods and tactics to gain and maintain power and control over the other person.

- It is a cycle that gets worse over time – not a one time 'incident'
- Abusers use jealousy, social status, mental and physical health, money and other tactics to be controlling and abusive – not just physical violence
- Leaving an abusive relationship is not always the best, safest or most realistic option for survivors

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Evidence Based Screening & Referral to Advocate: *Futures Without Violence intervention*

Evidenced Based Practice: CUES

C: Review limits of confidentiality
U: Universal Education
E: Empowerment, hand out 2 cards
S: Support
- Address related health issues
- Supported referral to a community-based
- advocate

20

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Addressing IPV In the Context of the CCO Model

Columbia Pacific CCO
Creating Health Together

- Members and providers *alike* may be survivors or know someone who is.
- Universal approaches and co-location of services positively affect our members *and* our provider networks.
- Reducing burden and stigma surrounding healthy relationship conversations, can positively impact the member-provider relationship.

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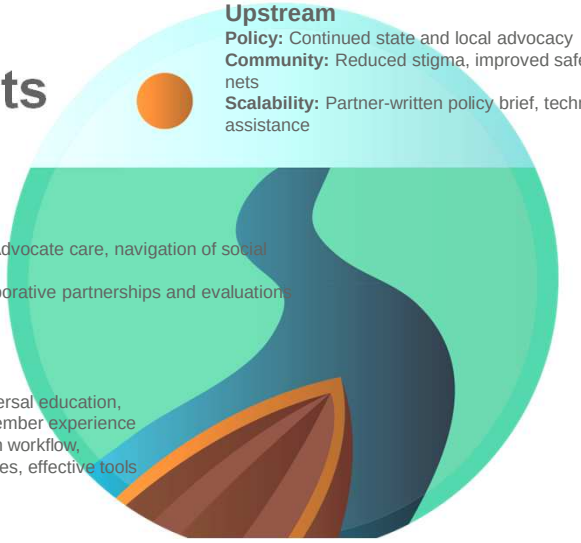
The Connection to Social Determinants



Upstream
Policy: Continued state and local advocacy
Community: Reduced stigma, improved safety-nets
Scalability: Partner-written policy brief, technical assistance

Midstream
Social Needs: Advocate care, navigation of social systems
Systems: Collaborative partnerships and evaluations

Downstream
Medical Interventions: Universal education, warm hand-offs, improved member experience
Provider Care: Confidence in workflow, knowledge of available services, effective tools

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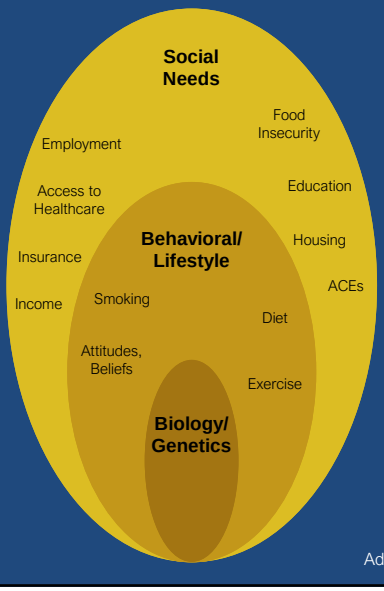
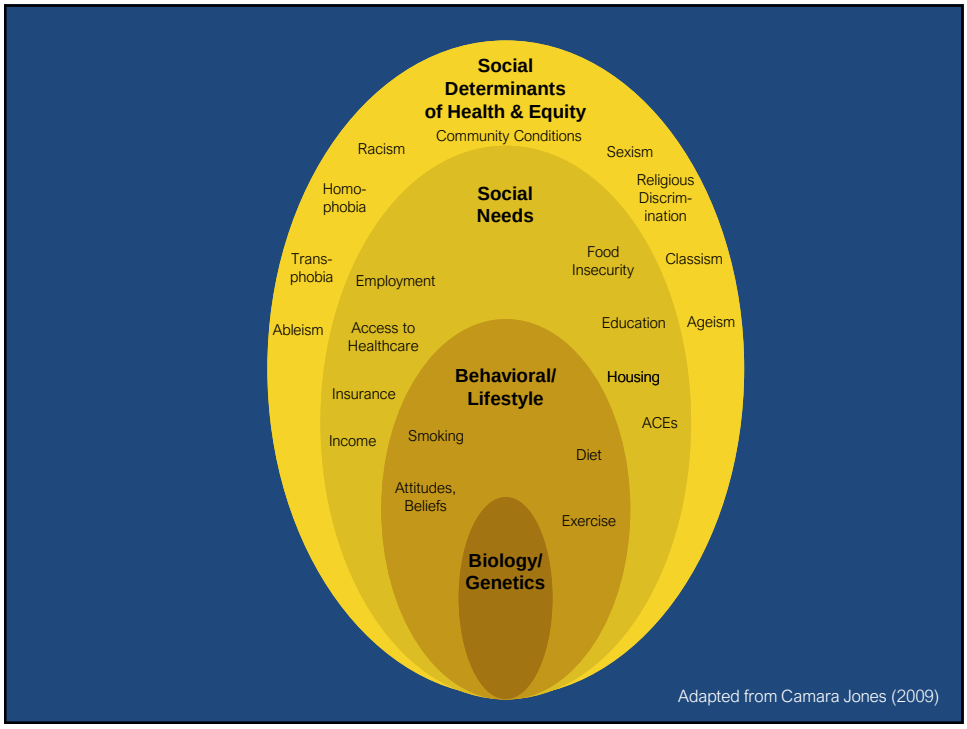
23

OHSU Richmond

Lesson #1: Addressing social determinants = addressing power



Adapted from Camara Jones (2009)



HEALTH AFFAIRS BLOG HEALTH EQUITY

RELATED TOPICS:
PUBLIC HEALTH | HEALTH EQUITY | SOCIAL DETERMINANTS OF HEALTH | DECISION MAKING | HEALTH DISPARITIES | POPULATION HEALTH

Power: The Most Fundamental Cause of Health Inequity?

Marjory Givens, David Kindig, Paula Tran Inzeo, Victoria Faust

FEBRUARY 1, 2018 10.1377/hblog20180129.731387

"Addressing [patient's social needs]… alone will not support our nation's efforts to reach our health potential.

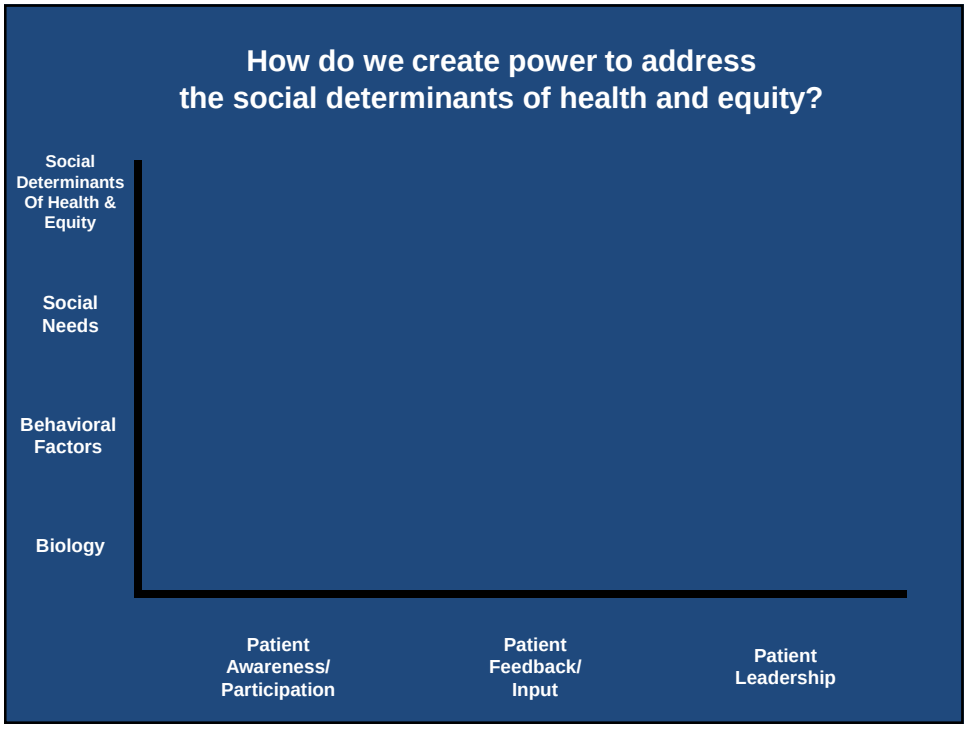
It is time to address power.

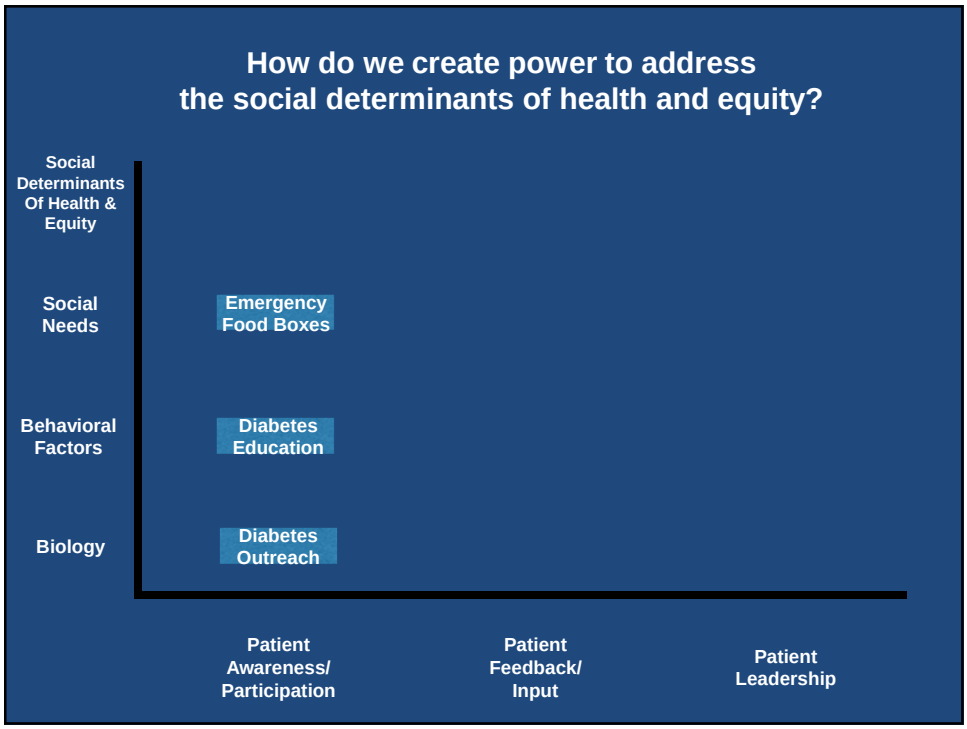
Advancing equity requires attention to power (as a determinant) and building power (as a process). "

Lesson #2: Addressing power = engaging patients in an entirely new way

Brightspots in social determinants create active resident/patient leaders

ReThink Health (2018)


How do we create power to address the social determinants of health and equity?
Social Determinants Of Health & Equity
Social Needs
Behavioral Factors
Biology
Patient Awareness/ Participation
Patient Feedback/ Input
Patient Leadership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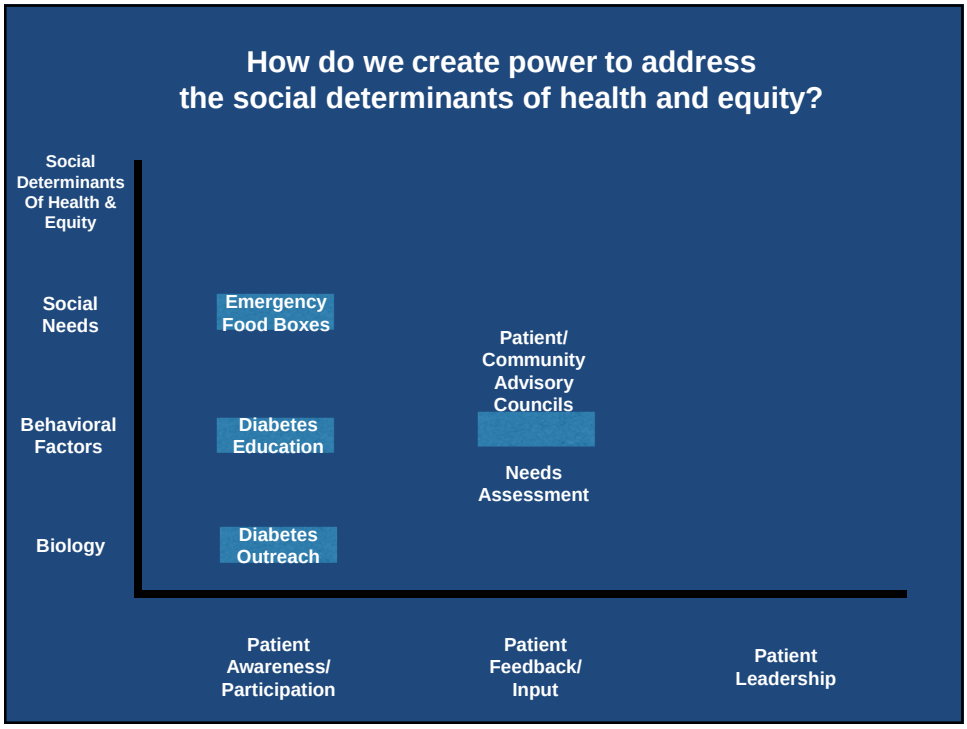
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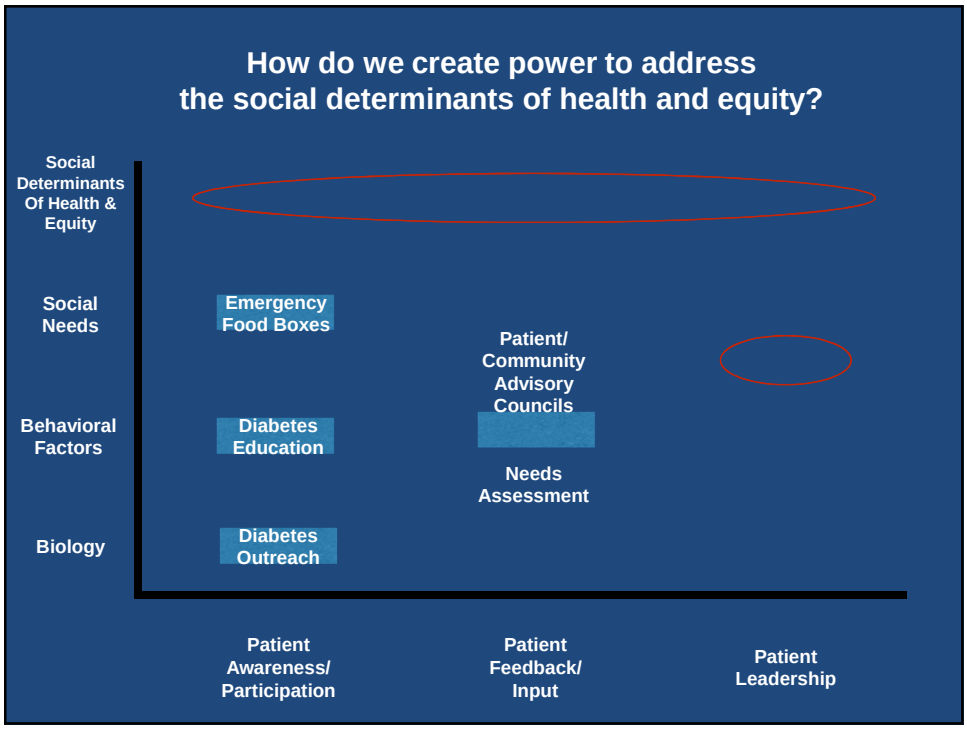
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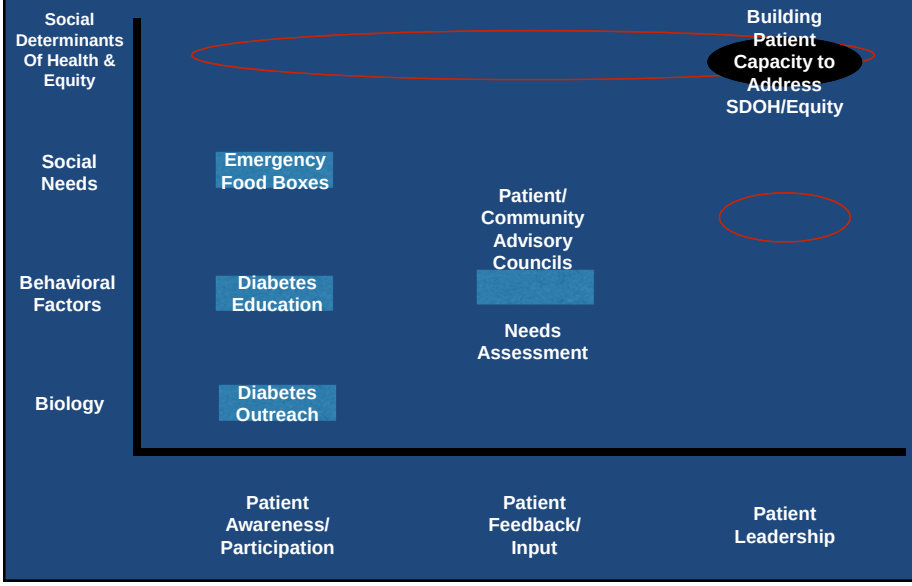

HEAL-R
HEALTH EQUITY AND LEADERSHIP | RICHMOND


HEAL-R
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Patients
Health Care
Community Organizations


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HEALTH EQUITY AND LEADERSHIP | RICHMOND
Patients
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HEAL-R
HEALTH EQUITY AND LEADERSHIP | RICHMOND

Listen	Engage	Develop	Act
• Identify shared social pressures • Listening sessions • One-to-ones	• Community building to cultivate trust, belonging, and shared purpose • HEAL-R Core Team Meetings	• Provide skills and opportunities for civic engagement, community organizing • In partnership with MACG	• Collective action against patient-identified SDOH • Community organizing • Coalition building

HEAL-R
HEALTH EQUITY AND LEADERSHIP | RICHMOND

Listen	Engage	Develop	Act
• >150 one-to-one meetings • 4 listening sessions • Affordable housing identified as issue	• ~40 patients attended • HEAL-R Core Team Meetings	• 20 patients completed community organizing and leadership training	• Patient-driven campaign for Tax Increment Financing with City Council and Portland Housing Advisory Committee

HEAL-R
HEALTH EQUITY AND LEADERSHIP | RICHMOND

Next Steps:

- Hiring a HEAL team (clinic-based health equity organizer, project manager, evaluation funding)
- Overhaul leadership curriculum into Health Equity Leadership Academy
- Evaluate and publish impacts
- Staff core team launching Health Equity Sub-Committee

OHSU Center for Diversity and Inclusion Champion Program Award

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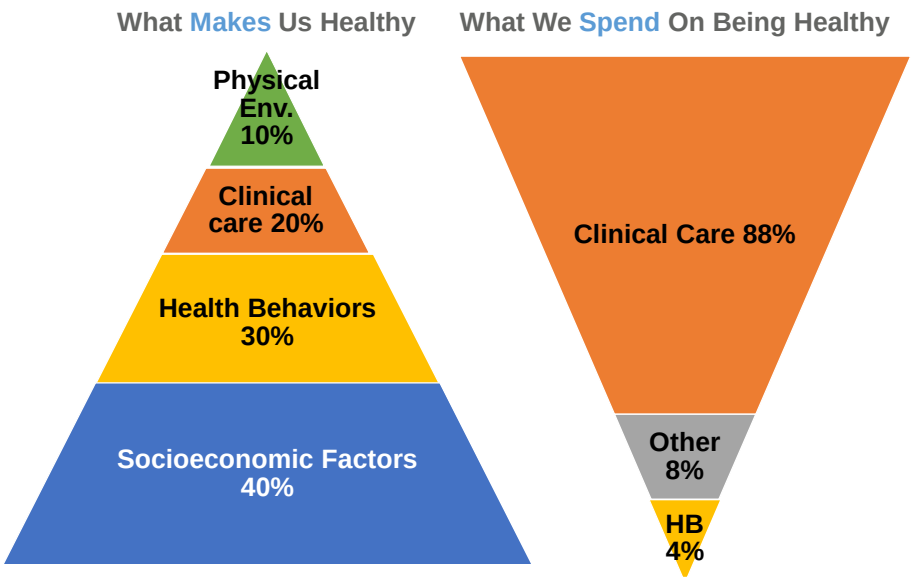
How Health Centers Can Help Payers and CCOs…

Priorities



Source: RWJF County Health Rankings; Derived from information from the Boston Foundation (June 2007).

Medicaid Investments to Address Social Needs

- CHCs of Benton and Linn Counties
- La Clinica
- Mosaic Medical
- OPCA

Read article here: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.05171

Opportunity for Alignment in CCO 2.0

Coordinated Care Organizations requirements	Opportunity with health center…
Increase CCO spending on SDOH and health equity	• Develop evaluation/expansion of food insecurity, housing, domestic violence, and transportation initiatives occurring in FQHCs and with CBOs. • Support staffing and technology to screen for social needs, consider data sharing with partners • Support expansion of risk stratification models
Encourage CCOs to share financial resources with non-clinical and public health providers for any incentive measure contributions	Continue to partner with CBOs that offer non-medical needs, formalize, evaluate, or hire staff to build on these collaborations.
Strengthen community advisory council (CAC)/CCO partnerships and ensure meaningful engagement of diverse consumers	FQHC Board members are 50% consumers – encourage participation on CAC/CCO Boards.
Require CCOs to develop internal infrastructure and investment to support CCO equity activities, including Traditional Health Workers	Hire and train THW roles that work out of CHCs and with CBOs.
Require CCOs to develop shared Community Health Assessment (CHA) and Community Health Improvement Plan (CHP) priorities and strategies	Ensure CHCs are part of CHA/CHIP priorities given reach and impact on communities around Oregon.

Supporting development of a local farmers market in resource-poor setting

Prescribing veggies/ Veggie Rx program

Treating diabetes

Source: Health Affairs 2019 https://bit.ly/2FwjiKv

Questions?

Moderator:

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