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.
CHCs Assess Patient Needs Broadly

What CHCs said are relevant to screen for to improve population health

Social Needs Programming at CHCs

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• 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

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Addressing Social Needs and Policy Change

IDENTIFYING AND ADDRESSING PATIENTS’ SOCIAL NEEDS

- 83% agree FPs should identify and help address patients’ SDoH
- 80% don’t have time to discuss SDoH with patients

ENGAGING WITH AND EMPOWERING COMMUNITIES

- 78% agree FPs should partner with community organizations to address community health disparities
- 64% aren’t properly staffed to address risk factors with patients

ADVOCATING FOR HEALTHY COMMUNITIES

- 75% agree FPs should advocate for public policies that address SDoH
- 56% feel unable to provide solutions to patients

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.

Defining the Work

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Adapted from: https://bit.ly/3MN1UA
Community partnership

Social needs AND social determinants of health

Scalability

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)
Community Health Centers of Benton and Linn Counties

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.

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.

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.
Growth
Expansion
Sustainability

Farm Stand - May to October
Local, organic produce for all!
Tuesday and Thursday
2:00 - 4:30
Health Services Building, 530 NW 21st Street

We are screening patients for food insecurity and providing groceries to increase access to healthy food in our clinic and the Corvallis Farmer's Market. We are also interested in increasing access to fruits, vegetables, and meats at the Health Services Building for healthy, fresh produce. Please stop by and see us!

For more information contact: community.care@oregonpo.or.us, 541-768-6228

Opportunities to spread best practices

<table>
<thead>
<tr>
<th>Activity</th>
<th>Expected Date(s)</th>
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<tbody>
<tr>
<td>Request for Proposal (RFP)</td>
<td>Environmental May 10, 2019</td>
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<tr>
<td>Question and Answer (QA)</td>
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<tr>
<td>Letter of Intent (LOI)</td>
<td>Due - Required May 30, 2019 by 4:00 pm</td>
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<tr>
<td>Request for Full Pilot Proposal</td>
<td>Due - June 15, 2019</td>
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<tr>
<td>Technical Assistance Meeting</td>
<td>Required June 17, 2019 to July 16, 2019</td>
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<tr>
<td>Pilot Proposal Due</td>
<td>July 22, 2019 by 4:00 pm</td>
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<tr>
<td>Pilot Proposal Review</td>
<td>By SST Committee July 25, 2019 and August 4, 2019</td>
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<tr>
<td>SST Committee Decision</td>
<td>August 22, 2019</td>
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<tr>
<td>Pilot Proposal Rejected</td>
<td>By August 30, 2019</td>
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<tr>
<td>Regional Planning/Grant Funding Decision</td>
<td>By September 12, 2019</td>
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<tr>
<td>Progress Notification of Pilot Award or Approval</td>
<td>By September 13, 2019</td>
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<tr>
<td>Transformation Department Issues Pilot Contracts</td>
<td>By November 1, 2019</td>
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<tr>
<td>Pilot Contracts Finalized</td>
<td>By November 30, 2019</td>
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<tr>
<td>Pilot Fundings/Payments Begin</td>
<td>January 1, 2020</td>
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Although we are on track to adhere to this timeline, it is subject to change as circumstances occur.

Transformation
CCO 2.0
Spreading best practices

Health coaching is better done in our homes, homes, and communities, creating a more engaged and healthier population. Oregon Health Authority (OHA) is committed to supporting those efforts and encouraging community health initiatives across the state. Oregon will receive an additional $70 million in federal funds to improve health care outcomes and build health equity. You can learn more at your convenience to help you improve your health. All information shared will be in a private and confidential.

In the last 12 months:
1. How many times did you talk to your doctor about...?
   a. Blood pressure        •11
   b. Cholesterol           •11
   c. Weight                •11
   d. Diet                  •11
2. How often did you take a prescription medication?
   a. Daily                  •11
   b. Other
3. How often did you have any other health problem?
   a. Cold                   •11
   b. Other
4. How often were you physically active?
   a. Daily                  •11
   b. Other
5. How often did you visit a doctor?
   a. Office                 •11
   b. Other

Would you like more information about food access in your community?
   Yes: 11
   No:   
If so, please share a brief note to contact you phone number, email, address, will

A health coach will follow up with you to share additional resources.

Our staff
Visit: https://www.oregonpo.or.us
Email: community.care@oregonpo.or.us
Phone: 541-768-6228
Key = Partnership

- Leverage expertise
- Collaborate for community benefit
- Transform way we provide care
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

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
Addressing IPV In the Context of the CCO Model

• 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.

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
OHSU Richmond
Lesson #1: Addressing social determinants = addressing power

Adapted from Camara Jones (2009)
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

Social Needs

Diabetes Outreach

Emergency Food Boxes

Diabetes Education
How do we create power to address the social determinants of health and equity?

Social Determinants Of Health & Equity

Social Needs

- Emergency Food Boxes
- Patient/Community Advisory Councils

Behavioral Factors

- Diabetes Education
- Needs Assessment

Biology

- Diabetes Outreach

Patient Awareness/Participation

Patient Feedback/Input

Patient Leadership

How do we create power to address the social determinants of health and equity?
How do we create power to address the social determinants of health and equity?

Social Determinants Of Health & Equity

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Emergency Food Boxes

Diabetes Education

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Patient/ Community Advisory Councils

Needs Assessment

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Patient Feedback/ Input

Patient Leadership

Building Patient Capacity to Address SDOH/Equity
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

Senate Bill 698: Hearing

OHSU Center for Diversity and Inclusion Champion Program Award
How Health Centers Can Help Payers and CCOs…
Priorities

What Makes Us Healthy

- Physical Env. 10%
- Clinical care 20%
- Health Behaviors 30%
- Socioeconomic Factors 40%

What We Spend On Being Healthy

- Clinical Care 88%
- Other 8%
- HB 4%

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


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Opportunity for Alignment in CCO 2.0

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<tr>
<th>Coordinated Care Organizations requirements</th>
<th>Opportunity with health center...</th>
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| 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. |

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**SOCIAL DETERMINANTS AND SOCIAL NEEDS: MOVING BEYOND MIDSTREAM**

- **Upstream**
  - Improve Community Conditions
  - Community Health Assessment

- **Midstream**
  - Individual Impact
  - Addressing Indirect Social Needs
  - Providing Clinical Care

- **Downstream**
  - Medical Interventions
  - Social workers, community health workers, and/or community-based organizations providing direct support/assistance to meet patient social needs

**TACTICS**

- Laws, policies, and regulations that create community conditions supporting health for all people
- Patient screening questions about social factors like housing and food access; use data to inform care and provide referrals

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

**Prescribing veggies/Veggie Rx program**

**Treating diabetes**


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Questions?

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