

# Oregon's Federally Qualified Health Centers: Building Capacity to Address the Social Determinants of Health

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JANUARY 2018 STATUS REPORT

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# Interview Questions

*Interviews with Oregon Federally Qualified Health Centers (FCHQs) staff were organized and conducted by Oregon Primary Care Association staff Stephanie Castano and Carly Hood Ronick during the months of October 2017 – January 2018.*

## Population Health Equity (APCM):

- 1) What is your status with regard to segmenting populations?
  - a. Are you still focusing on the same target population?
  - b. Any key barriers to implementation that OPCA can help address?
- 2) Do you have any clinic-level SDH data yet?

## Screening/Workflow:

- 3) Are you using PRAPARE or another screening tool? Any particular questions you're focusing on?
- 4) Who is asking the questions and where in the workflow are the questions asked?
- 5) Have you developed any relationships/referral processes with community partners? If so:
  - a. Which ones?
  - b. How are you partnering?

## Community Health Workers (CHWs):

- 6) Do you have Community Health Workers at any of your sites? If so, how many?
- 7) What is their primary role/connection to the care team?
- 8) What initiatives are supporting them (financially and in terms of capacity)?

## Empathic Inquiry:

- 9) Are you planning to participate in OPCA's Empathic Inquiry learning collaborative?
  - a. *Reminder to submit by Dec 15<sup>th</sup>*

## Technical Assistance Needs:

- 10) What are your greatest needs in terms of training/technical assistance related to:
  - a. Capturing patient-level data related to SDH commonly experienced by your patients?
  - b. Developing care strategies and workflows related to screening patients for SDH?
  - c. Fostering community partnerships to address SDH?

# La Clinica

*Location(s): Central Point, Medford, Phoenix*

*SDH leads interviewed: Brenda Johnson, Ali Salazar, Jillian Robinette, Maria Zambrano and Stephanie*

*APCM: √*

*Empathic Inquiry: √*

*EMR: OCHIN Epic*

*CCO(s): AllCare Health Plan, Jackson Care Connect, and PrimaryHealth of Josephine County.*

## Population Health Equity (PHE) for APCM:

- ❖ Main clinic - diabetics over 18 with an A1c between 9-12. Conduct screening once a year.
- ❖ West Medford clinic - Hep C population initially. Now all adults. Conduct every 6 months.

## Screening/Workflow:

- ❖ 877 screenings conducted (could be same patient multiple times).
- ❖ MA scrubs for SDH (review chart), Medical front desk (PSR) gives paper form to complete (see in EMR), MA reviews and puts in the EMR, Provider reviews in chart - for any positives MA gives a warm handoff to the wellness coach.

## Community Health Workers (CHWs):

No longer have CHWs. Wellness coaches - 4 total (one at every clinic). Used to be integrated behavioral health coaches. Since Senate Bill 238 passed, changed the name to wellness coaches and their competencies changed. Doing brief interventions, referral to treatment, goal setting, control substance programs.

## Community Partnerships:

- ❖ **Food Bank.** Mobile food pantry comes once a month.
- ❖ **Housing and utilities assistance.**
- ❖ **Social isolation** - referral to community support group.

## Identified TA in 2018:

- ❖ Community partnerships is the big one.
- ❖ Data help - 6 months from now - need analytics and help.
- ❖ Mindful of EI participants so that they can come back and train.

### CCO CONNECTION(s):

- ALLCARE - ADOPTING SOMETHING AROUND SDH IN 2018.
- JACKSON CARE CONNECT - PARTNERED WITH A LOCAL CSA - PAID FOR A LARGE MAJORITY OF THE BOXES AND THEN HAD FOOD STAMPS PAY THE REST. REFER TO WIC.

# CHCs of Benton and Linn Counties

*Location(s): Alea, Corvallis, Lebanon, Monroe, Sweet Home*

*SDH leads interviewed: Sherlyn Dahl & Christine Mosbaugh*

*APCM: √*

*Empathic Inquiry:*

*EMR: OCHIN Epic*

*CCO(s): InterCommunity Health Network CCO*

## Population Health Equity (PHE) for APCM:

- ❖ Diabetic population - No A1C in the last 6 months, 2 missed appts, and initial A1c above 9. Left 13 people
- ❖ 3 Primary questions around major barriers since implementation is over the phone.
- ❖ Three-prongs to our PHE strategy: 1. Segmentation with DM patients 2. Health Navigation as it is broadly infused in the organization; and 3. PRAPARE rollout as a way to collect clinic population level SDOH data.

## Screening/Workflow:

- ❖ Monroe clinic is piloting PRAPARE with Well Child Check visits at this time. Roughly 100 screened.
- ❖ Health navigator is screening, trying to schedule people 10-15 minutes before the visit. They come in, given forms including PRAPARE, visit with the navigator before the MA/Provider sees them. Changing the flow has been really hard for people; inserting HN into the flow is new.
- ❖ Export data to Excel. Able to manually tally and summarize findings. Developing report. Business analyst is willing to share.

## Community Health Workers (CHWs):

- ❖ 25 navigators with focus areas: O&E, clinical navigators. 3 in schools, Samaritan sites + oral health team.
- ❖ Clinical navigators are on the care team, doing the documentation. The others use dot phrases, but all ends up in 1 location in the EMR. "If you didn't document it, it didn't happen."
- ❖ Grant funded initially. Just rolled the navigators into APCM. O&E is funded through national. School navigators started out with CCO pilot and are now funded 1/2 by us, 1/2 by the school.

## Community Partnerships:

Address primarily: **Food, housing, transportation.** Navigators all carry a binder of resources - potentially put in GIS format, living documents.

## Identified TA in 2018:

- ❖ Building culture shift for SDH data collection.
- ❖ Strategies and workflows. Want to create a toolkit/tool based on others lessons learned.

### CCO CONNECTION(S):

- GROWTH FOR CHW PROGRAM HAS COME THROUGH IHNCCO PILOTS.
- DOES NOT USE THEIR HRS DOLLARS.
- SAT AT THE CCO TABLE EARLY & OFFERED TO PILOT.
- ED & STAFF SIT ON THE CCO SDH WORKGROUP.

# Multnomah County Health Department

*Location(s): Gresham, Portland*

*SDH leads interviewed: Breishon Dagostini, Dawn Shatzal, Ryan Linskey, Christine Palermo and Vanetta Abdellatif*

*APCM: √*

*Empathic Inquiry:*

*EMR: OCHIN Epic*

*CCO(s): CareOregon, Health Share, FamilyCare*

## Population Health Equity (PHE) for APCM:

- ❖ Previously focused on our patients with diabetes, and combine with the new diabetic program we were going to roll out. Learned nurses had so much to learn with the diabetic piece so we decided to pull out the SDH and come back and add it later.
- ❖ Just finished rolling it out in November. Beginning of March 2018 evaluate and may add SDH back in.

## Screening/Workflow:

- ❖ Dental - Risk assessment has questions around diet and nutrition.

## Community Health Workers (CHWs):

- ❖ 18 - Across multiple sites.
- ❖ They are part of team huddles, case consultations (provider may pull them in to appt/warm hand off), refer in Epic, consultations with behavioral health. Sit next to the team.
- ❖ Referral in Epic.
- ❖ Clinically prioritized/budgeted for them, and behavioral health integration grants. But not enough funding for them!

## Community Partnerships:

- ❖ Depends on the neighborhoods that we're talking about and the work that we're doing. Biggest issue area needs: **food, homelessness/housing stability, domestic violence.**
- ❖ Immigrant Refugee Community Organization, Volunteer Lawyers Association (VLA), CODA, Community Action Partner (CAP) - HIV clinics,

## Identified TA in 2018:

- ❖ None identified.

### CCO CONNECTION(s):

- DID NOT DISCUSS

# Valley Family Health Care

*Location(s): Nyssa, Ontario, Vale*

*SDH leads interviewed: McKenzie Wilson*

*APCM: √*

*Empathic Inquiry: √*

*EMR: Greenway Intergy*

*CCO(s): Eastern Oregon CCO*

## Population Health Equity (PHE) for APCM:

- ❖ New to APCM.

## Screening/Workflow:

- ❖ Not currently, but looking to in the next couple of months. Looking at PRAPARE.
- ❖ Considering CHWs or care coordinators to ask the questions. Care coordinators role is being defined. Will PDSA both. "We don't know what we don't know until we try."

## Community Health Workers (CHWs):

- ❖ 4 certified including manager, 1 yet to be trained/certified. Primary role is to help with enrollment and resource navigation.
- ❖ Work out of our outreach center - separate physical location. They get referrals in 3 ways: from clinic and EMR (recent), self-referrals via walk in or appt, and referrals from out in the community.
- ❖ Ok understanding of what CHWs do, so clinicians refer to CHWs but don't interact with the care team much. They have a regular meeting with care coordinators, mental health and behavioral health, and drug assistance program, but they have frequent communication via phone with people in the clinic - providers and nurses if they are trying to resolve something. They are ok at documenting navigation.
- ❖ At this point, funded primarily through HRSA for enabling services which both CHWs and enrollment roll into, and receive some funding through NEON's community hub. Are developing workflows to support EOCCO billable services.
- ❖ Not a huge source of revenue. We did participate in the EOCCO ECHO course to learn how to start billing them for CHW services. Implementing a clinical supervisor to be able to bill for that.

## Community Partnerships:

### **Food, utilities support and mental/behavioral health.**

Food bank, WIC, Community in Action - utilities support, Lifeways - Mental/behavioral health (Medicaid contract) - counseling, crisis team.

## Identified TA in 2018:

- ❖ None identified yet.

### **CCO CONNECTION(s):**

- EOCCO ALLOWS BILLING FOR CHWs & SUBSIDIZES CHW TRAINING.
- EOCCO - INNOVATION GRANT WILL BE APPLYING SOON.
- COMMUNITY ADVISOR COUNCIL (CAC) AND DATA SHARING.
- EOCCO OFFERED HEALTH FAIR SPACE TO MEET ADOLESCENT WELL-CHILD VISITS.

# LaPine Community Health Center

*Location(s): Christmas Valley, Gilchrist, LaPine, and Sunriver*

*SDH leads interviewed: Charla DeHate and Marie Manes*

*APCM:*

*Empathic Inquiry:*

*EMR: OCHIN Epic*

*CCO(s): Pacific Source*

## Screening/Workflow:

- ❖ Using PRAPARE in Epic. Reviewed it with a workgroup. Worked with Mosaic and did a presentation for staff on SDH.
- ❖ Questions being ask with front desk intake forms on tablets. 3-4 front desk staff. ASQ and SBIRT, front desk check in, will include SDH questions on there.
- ❖ First within the OCHIN collaborative to use tablets. Push back from staff, patients won't be able to answer questions on the tablets. Having someone there to help will be valuable. Idea, 1 person behind the desk, 2-3 sitting with patients in the waiting room and helping them if they needed it.
- ❖ Will test with 2 provider and MA teams. Once we know it's working well, will roll out.
- ❖ Likely have outreach dept (same as CHWs) meet with people depending on their answers.
- ❖ Frequency will depending on how often patients come in.

## Community Health Workers (CHWs):

- ❖ 4.5 FTE (.5 in Christmas Valley, 4 in LaPine).
- ❖ Send out to other sites or available by phone as needed.
- ❖ MA's or providers come and get them if they need them right away. Instant messaging. Not part of team huddles or panel management.
- ❖ Do put data into the EMR.
- ❖ Funding:
  - 1 through expanded services grant from HRSA that rolls into the 330 grant.
  - Oregon state outreach workers (OSOW) funding.
  - 3.5 are funded ourselves.

## Community Partnerships:

**Food, transportation, housing (in Bend):** Business community, Community kitchen, St. Vincent DePaul.

## Identified TA in 2018:

- ❖ Talked to site specialist about building a custom report for data.
- ❖ Need help on workflows.
- ❖ Lots community work with Pacific Source and Central Oregon Health Council.

### CCO CONNECTION(s):

- QI MONEY FROM PACIFIC SOURCE FOR TABLETS.
- MONEY FOR GAS CARDS FOR PATIENTS WITH TRANSPORTATION NEEDS.



# Rinehart Clinic

*Location(s): Wheeler*

*SDH leads interviewed: Denise Weiss and Katie Boner*

*APCM: √*

*Empathic Inquiry: √*

*EMR: OCHIN Epic*

*CCO(s): Columbia Pacific CCO*

## Population Health Equity (PHE) for APCM:

- ❖ Hypertension patients and expanded to chronic pain patients. Diabetic patients (next population).
- ❖ Focus on food, transportation and exercise.
- ❖ Social isolation seems to be a common theme that has impacted what we are doing - offering a lot more group classes to engage patients. Surveys at completion of groups. Finding that no matter what the topic, patients feel more connected.

## Screening/Workflow:

- ❖ Huddle prep each afternoon. Each nurse works with 1 provider, identify 1 patient per day per provider to screen. Two RNs on staff, nurses and panel manager coordinate panel prep, look at chart for preventive screenings, why coming in, etc.
- ❖ MA's room the patient, handoff to nurse who goes into the exam room, complete form with the patient and complete on paper. Either conversation or self-administered. Send questionnaires to Katie (O&E) who puts into EHR and spreadsheet.
- ❖ RNs and enrollment navigator will continue following up by phone for any + food insecurity screenings w/in 1 month.
- ❖ Education RNs & front desk staff around distribution of gas cards to patients who screen + for transportation struggles.
- ❖ Denise implementing walking club w/ RNs around discounted exercise classes.

## Community Health Workers (CHWs):

- ❖ Yes 2. One community based and funded by Soysano since January of 2016.
- ❖ The other since Sept 2017 and has outreach/and insurance enrollment funding through Dept of Consumer and Business services.
- ❖ Participate in huddles.

## Community Partnerships:

**Food, transportation (gas cards self-funded), and social isolation.**  
Farm for CSA, recreation district for classes, running own classes.

## Identified TA in 2018:

- ❖ Connect with Ned/OCHIN around how to develop reports.
- ❖ Consider food resources for those from outside the county (not eligible for food bank).

### CCO CONNECTION(s):

- INCENTIVE GRANT FUNDING TO EXPAND COMMUNITY PARTNERSHIPS 2017-2018.
- SIT ON Cp3 WORKGROUP, MEETING WITH OTHER CLINICS FUNDED THROUGH CCO TO LEARN.

# Winding Waters

*Location(s): Enterprise and Joseph*

*SDH leads interviewed: Meg Bowen and Keli Christman*

*APCM: √*

*Empathic Inquiry:*

*EMR: OCHIN Epic*

*CCO(s): Eastern Oregon CCO*

## Population Health Equity (PHE) for APCM:

- ❖ We're using the Charlson Risk Score to determine who to interview (patients w/ score 6 and above). Switched to all patients annually. No pushback from patients. Needs were the same whether or not their Charlson Risk Score was high or not.
- ❖ Data able to pull from OCHIN. Going back to January.

## Screening/Workflow:

- ❖ Would go into the room before visit and ask questions. Took too long so now self-assessments administered by paper.
- ❖ MAs reviews them, and then pass info to the provider. Added a question on wanting to talk with a CHW. If SDoH needs identified, there is a warm hand off to a CHW. CHW enters into Epic.
- ❖ Even if they indicated no to CHW. Do you have anybody to call in case of emergency? If no, CHW was engaged. Give her a card and say she's there for them.

## Community Health Workers (CHWs):

- ❖ Yes, 4. CHWs round in the hospital, do home visits, work in the schools. They'll chart into the record what services they connect the patient to. Wood, food, etc. Veggie Rx program through BH coach, OFB.
- ❖ Team based pods, everyone sits around the pods - all sit together so they can chat and talk regularly.
- ❖ CHW's communicate new resources to everyone.
- ❖ Initially funded internally. Now funders: NEON - NE Oregon Network, EOCCO, AIMS grant

## Community Partnerships:

- ❖ Patients screening pos – as of Nov 12. n =131. 37 report it was hard to pay for basics; 16 very hard to pay for basics. 4 questions we highlight - **hard to pay for basics, utilities, food, transportation**. Significant need around **housing**.
- ❖ NEON - NE Oregon Network - good relationship with them and pathways grant through HRSA.; EOCCO ; Building Healthy Families

## Identified TA in 2018:

- ❖ New and innovative ways to use CHWs (ECHO collaborative)
- ❖ Not sure how to start/keep up to date a list of resources. Idea: After the clinic closed, did a happy hour. Hosted it with wine/cheese that other non-clinical nonprofits were invited to share.

### CCO CONNECTION(S):

- EOCCO SUPPORT OF CHW TRAINING AND ALLOWED TO BE BILLED.

# Rogue Community Health

*Location(s): Ashland, Butte Falls, Eagle Point, Medford, Prospect, White City*

*SDH leads interviewed: William North and Ryan Blair*

*APCM: √*

*Empathic Inquiry: √*

*EMR: OCHIN Epic*

*CCO(s): Jackson Care Connect, AllCare, Umpqua Health Alliance (?)*

## Population Health Equity (PHE) for APCM:

- ❖ Original target population: 100 DM patients with A1C > 9.
- ❖ Eventually served 215 patients with the PRAPARE tool. Responses led to 39% being food insecurity. Switched emphasis.
- ❖ Jan 2018 - White City focus.
- ❖ 3-4 weeks worth of data. We are tracking our referrals. Because we tested in Ashland we can start. Willing to share data.

## Screening/Workflow:

- ❖ At White City - CHW meeting with patients at the start of the visit for 7-10 minutes as part of the welcome packet. If needs are found, CHWs have been completing the PRAPARE tool in Epic in 48 hours.
- ❖ Use pre-screener. Willing to share.

## Community Health Workers (CHWs):

- ❖ 8 CHWs, budgeted for 10 this year. Looking to double that next year depending on political climate.
- ❖ Have CHWs at 3 sites, sometimes at 4th site. Focus is on SDH.
- ❖ CHW 1, 2 level based on skills. Want to have a CHW 3. Opportunity to growth.
- ❖ Financially supported by APCM.
- ❖ Trauma informed practice - consultant Bob Lieberman -- expert trainer. Engaged with us in a project to occur over the next 8 months that will allow TIC to be part of our policies, procedures and how we interact with each other.

## Community Partnerships:

- ❖ Creating a virtual network - formal network based on a shared understanding of what we're trying to accomplish.
- ❖ In-patient treatment services - Addiction services; Goodwill, YMCA, HeadStart, ACCESS - **food insecurity, poverty, homelessness and housing; consumer credit counseling.**
- ❖ Engaging in client management - outside of EHR to avoid PHI not being shared. Running by Feb.
- ❖ Using CHW to engage with referring partners.
- ❖ 2 months into a location expansion of mobile food pantry - with CCOs, ACCESS, Food Pantry, La Clinica.

## Identified TA in 2018:

- ❖ Need clear guidelines so that things aren't changing so we can track a true number.
- ❖ Panel management and transitions of care - triage.
- ❖ Coding and documentation of complexity - z codes.

### CCO CONNECTION(s):

- 3 CCOs. CCOs INVITED TO PARTICIPATE IN NETWORK, DIDN'T GET INVOLVED INITIALLY.

# Tillamook County Health Department

*Location(s): Cloverdale, Rockaway Beach, Tillamook*

*SDH leads interviewed: Marlene Putnam and Autumn Bruce*

*APCM:*

*Empathic Inquiry:*

*EMR: OCHIN Epic*

*CCO(s): Columbia Pacific CCO*

## Screening/Workflow:

- ❖ 12 years and older are the target. Using a wellness questionnaire that we developed, questions about nutrition and relationships (IPV), SBIRT, PHQ9, food insecurity, intimate partner violence, ask about homelessness, veterans.
- ❖ We do the screening when the patient comes in, address when they answer. Screened by paper, reviewed by MA or nurse.
- ❖ For needs with:
  - IPV: Advocate through the women's resource center - advocate comes out to answer.
  - Nutrition: we have a packet we review with the patient with available resources - farmers market, food bank. Care coordinator, advocate, etc.

## Community Health Workers (CHWs):

- ❖ No. Those are our care coordinators - we have about 9 (7 of whom are bilingual). Dental coordinators too.
- ❖ Coordinate care - work with provider to make sure veterans are getting what they need. Do not have a care coordinator for each team. 1 does most of the referrals, 1 does insurance assistance, pregnancy coordinators.
- ❖ They go with home visiting as a resource; don't go out into the community.
- ❖ Work as Spanish/English interpreters, enrollment, connection to resources (via phone or in clinic).
- ❖ Funded through grants and patient-generated revenue.

## Community Partnerships:

- ❖ Tillamook Family Counseling Center (mental health)
- ❖ CARE (community action organization)
- ❖ Nutrition: DHS - SNAP and food stamps, WIC - identifying and connecting folks to service. Oregon Food Bank; Food Roots.
- ❖ Women's resource center - provides housing and clothing.

## Identified TA in 2018:

- ❖ Hard to say until we get into the workflow. We have a workgroup meeting that talks monthly about this.
- ❖ Being able to look at a regular report. Closing the loop on the referrals is hard to track - could the EHR address this?

### CCO CONNECTION(s):

- GRANT FUNDING PENDING WITH CCO AROUND GETTING A CHW. PARTNERING WITH CARE TO SUPPORT OUR MORE DIFFICULT PATIENTS - HOUSING, MENTAL HEALTH. DIABETES FOCUS. NUTRITIONIST TO HELP CARE COORDINATE.

## Outside In

*Location(s): Portland, Milwaukie*

*SDH leads interviewed: Katheryn Anderson and Brian Little*

*APCM:*

*Empathic Inquiry:*

*EMR: OCHIN Epic*

*CCO(s): CareOregon (and FamilyCare)*

### Screening/Workflow:

- ❖ We are screening. Helpful the flowsheet is in the EMR, MA's are so busy. If they had had to go to a separate screen, this would have been much harder to implement - much better when it's streamline.
- ❖ Built out self-screening tool and put in rooms - food, clothing, legal and vet care (had concrete resources on the other side of them). Built it out so that folks could refer without putting anything into the EMR to get physician buy in.
- ❖ Clinicians would never connect to resources. We've been able to change that culture within the clinic - finally able to collect data on food insecurity as a result of this. Been less data intensive, to get buy in for clinical leadership.
- ❖ Now put into EMR as of November - just food insecurity screening. Our perceived need is we have a lot of food insecurity and a lot of housing insecurity.
- ❖ Front desk hands food insecurity out. Patient's report on form - MA's trained to refer patient to community resources and put in EMR. Front page of SBIRT PHQ9.

Food insecurity questions:

- Do you want help with food resources today?
  - Are you currently enrolled in SNAP?
  - If you're interested in food resources, as your MA for a pink referral slip or go to the front desk.
- ❖ Waiting to look at the data since it was so recent.
  - ❖ In terms of adding data into the EMR, our toughest issue is time. How to streamline that and make it something that is not putting undue burden staff.

### Community Health Workers (CHWs):

- ❖ Not yet. Want them though! Very interested in CCO funding for CHWs. Want the names of a contact person at CCO level to help fund this work.

### Community Partnerships:

- ❖ A lot of work strengthening this. Panel managers are our hub.

### Identified TA in 2018:

- ❖ Looking for new funding strategies for CHWs - CCO HRS spending.
- ❖ As we get more and more data, what do we do with it. Have a QA coordinator here, but being able to partner with your team to discuss how to display this and communicate it.

### CCO CONNECTION(s):

- LOOKING FOR OPPORTUNITY TO INCREASE FUNDING FOR CHWs.

# Columbia River Community Health Services

*Location(s): Boardman*

*SDH leads interviewed: Seth Whitmer, Sonja, and Yesica Pena*

*APCM:*

*Empathic Inquiry: ✓*

*EMR: Athena*

*CCO(s): Eastern Oregon CCO*

## Screening/Workflow:

- ❖ Not familiar with PRAPARE.
- ❖ Looking at doing a VeggieRx. Applied to a couple of grants - We are now looking at opening a food bank as there is more solid research of this having a long term positive effect on health outcomes.
- ❖ Still building who/where in the workflow.

## Community Health Workers (CHWs):

- ❖ No. We've been talking about getting some. Talking about how to bill for it, what they would be doing. We don't want to hire them and not have them be busy.
- ❖ EOCCO is very supportive of this. Looking at possibly funding CHWs to bill for phone calls. Trying to figure out how that would work. Prior administration had an experience where we hired a bunch of nurses and had to let them go.

## Community Partnerships:

- ❖ Our LCAC public health, **head start, early childhood development**, school care coordinators. Several MOUs out there, **very limited housing/food resources**.
- ❖ Don't have a food bank, people have to go to neighboring communities for food. How can our clinic help support that? Fresh produce not a problem, so much agriculture but need more than just what's in season.

## Identified TA in 2018:

N/A

### CCO CONNECTION(S):

- LOOKING AT HOW TO GET EOCCO TO BILL FOR CHWs WHO REACH OUT VIA PHONE.

# One Community Health

*Location(s): Hood River, The Dalles*

*SDH leads interviewed: Alicia Swift*

*APCM:*

*Empathic Inquiry:*

*EMR: OCHIN Epic*

*CCO(s): Pacific Source CCO*

## Screening/Workflow:

- ❖ Medical assistants, ask the 2 questions when they room the patient. Sometimes administered at the front desk. Focused on food insecurity. Questions we are using with every patient once a year:
  - 1) in the past 12 months have you worried about running out of food?
  - 2) have you run out of food?
- ❖ We deem someone food insecure if they say sometimes or often to either of these.
- ❖ Run a report from EPIC each month to show us how many people we screened & were positive.
- ❖ In our dental department, the front desk employees administer the food insecurity questions with the medical history form. On paper forms currently, don't put things into the EHR necessarily.

## Community Health Workers (CHWs):

- ❖ 8 CHW split between Hood River and The Dalles.
- ❖ Assist with in-clinic visits - 2 types: Diabetic management appt - they get a 15 minute check in with CHWs before this appt automatically. Full hour appt - related to ANY social determinant of health you can think of. May start with prioritization and then move through specific goals. All free of charge.
- ❖ Have an action plan template they can use, but most is conversation and not a tool.
- ❖ Outside the clinic - lots of outreach. Lead 12 week courses on food, attend community events.
- ❖ Funded by grants. HRSA grant for classes, Providence grant. CHWs have always been supported internally.

## Community Partnerships:

- ❖ Next Door - **trainings/mentorship**. Do a lot of different events with them - eye screening, food events.
- ❖ Local hospital (mid-columbia medical center) and Providence Hood River - ask for "experts" to come speak in we hold a class.
- ❖ Food bank - Oregon and regional food pantry. Held a flu clinic and the food bank donated 2k lbs.
- ❖ OSU Extension - **food demos**, farmers markets with CHWs, **nutrition education**.
- ❖ Blue Zones - launching in the Dalles. Trying to become a working site so invite staff to come.
- ❖ Gorge Grown Food - **Veggie Rx Program**. Demand is increasing because screening is becoming better. More funding for food vouchers. \$18k internally this year, does not meet the demands. Looking forward to seeing that the budget will look like.

## Identified TA in 2018:

- ❖ Reach out in spring.

### CCO CONNECTION(s):

- RECEIVED \$4,000 DOLLARS IN FLEXIBLE SERVICES. PACIFIC SOURCE DONATED THE MONEY MID-JUNE 2017. BEEN FANTASTIC AND VERY CONSISTENT AND USEFUL. JUST FOR OHP PATIENTS.

# Coast Community Health Center

*Location(s): Bandon and Port Orford*

*SDH leads interviewed: Linda Maxon and Lennae*

*APCM:*

*Empathic Inquiry: √*

*EMR: eClinicalWorks*

*CCO(s): AllCare and Wester Oregon Advanced Health*

## Screening/Workflow:

- ❖ Starting to talk to medical director about using PRAPARE. Made contact with trainer to help us on EHR.
- ❖ Consider using food bank 2 questionnaire in exam room – as prescreen. If anyone flags positive, conduct PRAPARE with nurse care managers or CHWs. Same visit but not in the exam room or as a follow up.

## Community Health Workers (CHWs):

- ❖ 2 certified CHWs. We have 5 of us on the team that work on O&E – and there's cross over in all of our duties. Some are application assisters under OHA grant, but they do a lot more/crossover.
- ❖ All of the patient interactions related to SDH comes from the providers themselves or the nurse navigators. They utilize O&E as resource connection and health navigation.
- ❖ Looking at trying to get the CHWs more involved in coaching patients with co-morbidities.
- ❖ Outreach Medicaid OHA grant includes 2 positions from FCHQ grant (base), out-station/outreach worker, 1 position and 2/3 of benefits. We don't get reimbursed until next year.
- ❖ Medical team unhappy because they can't walk down the hall and have a CHW. Dr. McCelvy – MD. Our outreach team is upset because they don't have a lot of help.

## Community Partnerships:

- ❖ **Food and transportation.** Just started a program – signed a contract to do a “**cooking matters**” program and will look at **Veggie Rx**.
- ❖ Oregon Community Action Agency (ORCAA) – supplies information to 5 **food banks**. Cross two counties - Great, but also challenging because it's a wide catchment area. Very rural which makes it hard. Those using the food bank don't necessarily have **transportation**.
- ❖ We have a lot of community partners! Can't do our work without integration.
- ❖ **No mass transit** so it's really tough. Those who don't live on highway 101 can't get around.

## Identified TA in 2018:

- ❖ Super helpful to have conversations with the CHCs that are rural.
- ❖ Linda: 2 areas – sharing best practices and lessons learned with regard to food and/or homelessness.
- ❖ OPCA's health literacy conversations are very important.
- ❖ Lennae: EHR integration is high on my list – methodology we've been using (warm hand offs, tracking, phone calls). Putting things into a chart!
- ❖ Outreach center in Port Orchard – almost like a day shelter that we're running. Need to capture data – nothing there!
- ❖ Want to start with screening – providers don't necessarily.

## CCO CONNECTION(S):

- GOOD RELATIONSHIP WITH ALLCARE, NOT AS VIBRANT WITH THE OTHER.
- REALLY COOL TO SEE CCOs AND OHA STARTED TO USE SDH TERMINOLOGY. EVEN IN 2014 WASN'T TALKING ABOUT IT.



# The Wallace Medical Concern

*Location(s): Gresham and Portland*

*SDH leads interviewed: Sara Jade, Lauren Enciso, and Lisa Cline*

*APCM: √*

*Empathic Inquiry: √*

*EMR: OCHIN Epic*

*CCO(s): HealthShare/CareOregon*

## Population Health Equity (PHE) for APCM:

- ❖ Initially didn't get very many - 7-8 patients. No shows make it hard when we have a narrow population.
- ❖ Developed a modified version of PRAPARE (with specific questions about diabetes), added questions specific to diabetes, trying to engage our diabetic patients with the tool.
- ❖ We have changed our target population from uncontrolled diabetics to new patients so that we can capture more data. We will start screening all new patients at our Gresham location in March.

## Screening/Workflow:

- ❖ Previously done by OHSU nursing students who take on various projects at WMC every semester.
- ❖ When we implement our new strategy in March receptionists will schedule new patients to speak with our CHW over the phone or in person. CHW will go through questionnaire and input information in EMR for Provider to review before their appt.

## Community Health Workers (CHWs):

- ❖ 3 - Rockaway site
- ❖ Essential part of patient's care teams who have close understanding of SDH.
- ❖ Make a variety of social service referrals (shelters, rent & electric bill assistance, food banks, veterinary care, employment assistance etc).
- ❖ Spend a significant amount of time scheduling rides to get patients to appts and specialist appts.
- ❖ All are certified OHP enrollment assisters and assist completing applications for OHP and SNAP.
- ❖ Years past they've been funded by grants. Budgeted in our main grant now. We fundraise, keep track of whose salary is covered. Raising funds to add an additional one for ED outreach and shelter connection.

## Community Partnerships:

- ❖ Central City Concern for **detox support**, Lifeworks NW, Worksource & New Avenues for Youth- **GED/job and resource**, PaNOW, Latino Network, Human solutions, Home Forward Rosewood Initiative, Head Start, **food banks**, and **shelters**.

## Identified TA in 2018:

- ❖ Staff have been interested in getting trained in MI. Offering that would be of benefit to Wallace staff.
- ❖ Organizational trauma informed care training would be good.
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- ❖ Organizational trauma informed care training would be good.

## CCO CONNECTION(s):

NOT DISCUSSED

# Virginia Garcia Memorial Health Center

*Location(s): Beaverton, Cornelius, Forest Grove, Hillsboro, McMinnville, Newberg, Tigard, Tualatin, and Willamina*

*SDH leads interviewed: Ignolia Duyck, Laura Byerly, Kendra Powell, Gil Munoz, Sarah Deines (new role), and JoAnn Helmstreet*

*APCM: √*

*Empathic Inquiry:*

*EMR: OCHIN Epic*

*CCO(s): HealthShare (and FamilyCare)*

## Population Health Equity (PHE) for APCM:

- ❖ Would like to implement with CHWs in clinical pharmacy (high utilizers);
- ❖ Kendra with transitions of care appointment (from hospital back to primary care);
- ❖ Outreach & enrollment (Care STEPS as well) - We could apply PRAPARE to this population.

## Screening/Workflow:

- ❖ Mobile clinic was an example of how we're addressing SDH by going out into the clinics and providing an array of services - other community partners (food, clothing, legal assistance).

## Community Health Workers (CHWs):

- ❖ Yes, we do. 9 PCCCOWS and CHWs. We don't have enough of them! Precious resource within the clinic. That dimension of the model is one that needs to be built out.
- ❖ Ignolia oversees: certified CHWs - serve whole organization in different activities, all the clinics, more outreach focused (Cornelius clinics).
- ❖ JoAnn oversees: PCCCOWs - monthly group clinical consultation with them to provide a group for them. Foundation and philosophy is similar to CHW. Biggest difference is that they are assigned to patients in their clinic. Stay within the clinic.
- ❖ PCCCOWs sit in the team room - warm hand off. Not necessarily at the level where we've considered the protocols and procedures for allowing them to prescribe.
- ❖ Funded by APM mainly, federal bureau grants as well. Host of other grants that can help with supporting the activities of CHWs.

## Community Partnerships:

- ❖ Local aging and disability services office; Community Action - referrals for energy assistance; benefits that may be available - **transportation, ride connection; food** varies based on location, Oregon Food Bank to ID zip code - care to share food boxes and local churches; ride connection - receive bus passes and daily tickets for our patients - 5 years - \$20k dollars.

## Identified TA in 2018:

- ❖ Support PCCCOW with TA if needed. Going to talk internally.

## CCO CONNECTION(s):

NOT DISCUSSED

# Umpqua Community Health Center

*Location(s):* Glide, Myrtle Creek, Roseburg, Winston, Sutherlin

*SDH leads interviewed:* KC Bolton and Elizabeth Droscher

*APCM:*

*Empathic Inquiry:*

*EMR:* Centricity

*CCO(s):* Umpqua Health Alliance

## Screening/Workflow:

- ❖ Not using PRAPARE. We are part of the I am Healthy/Soysano grant. Questionnaire in there that looks at SDH.
- ❖ Tighter integration with social services - our staff are committed, we are a good lead agent.
- ❖ EMR - Centricity. Looking at ability to connect to internet directly, would only be constrained by internet speed. Could use a regular.
- ❖ Happy to talk with the vendor, and share PRAPARE. Going out to Boston next week - 90 days hope to close on new EMR.

## Community Health Workers (CHWs):

- ❖ None on staff.

## Community Partnerships:

- ❖ Senior staff looking at where we go strategically. Applying for HRSA grant to set up the Southern Oregon Mobile Consortia Initiative (SOMCI). With Food Bank and United Way so bigger than health care - broad grant in terms of what you can use it for.
- ❖ Mobile primary care clinic - embedded in that clinic are direct connects to social services as part of intake. Our partners do this as part of their day job.
- ❖ Because of how widely dispersed our population is, we have a tough time answering what we are doing in rural towns. Can't set up brick and mortar in each town.
- ❖ **United Way, Food Bank, Ford Family Foundation, Family Development Center** (kid 0 -5, families in at risk environments), AHEC SW, Public health network (embedded in the network ourselves).
- ❖ A few of the staff and KC are advisory members for early-childhood development efforts. Douglas County early childhood development hub - education side. Want to understand the healthcare piece to optimize childhood education.
- ❖ KC sits on a directors for the Blue Zones project - peripherally involved.
- ❖ Veterans free BBQ - For the Love of Paws - **free rabies vaccination**. Sliding scale vet. MOU with them for drugs we aren't going to use anymore.

## Identified TA in 2018:

- ❖ Peer learning opportunities.
- ❖ Cautious about food insecurity metric and understanding what we are measuring.

### **CCO CONNECTION(s):**

- **MINDFUL OF CCOs AND COMPETITION WITH CHCs.**

# Siskiyou Community Health Center

*Location(s): Cave Junction, Grants Pass*

*SDH leads interviewed: Rich Booth, Kris Miller*

*APCM:*

*Empathic Inquiry:*

*EMR: NextGen*

*CCO(s):*

## Screening/Workflow:

- ❖ Not screening yet, but having the MA do it when rooming mimics where we are at in terms of other screening.
- ❖ Interested in tablets/kiosks - cost effective - would do it without a grant.
- ❖ We understand the higher level reason/need, but competing demands. Curious about why to collect data if you don't have resources.

## Community Health Workers (CHWs):

- ❖ None on staff.

## Community Partnerships:

- ❖ None discussed.

## Identified TA in 2018:

- ❖ Outreach on: healthy families, Blue Zone project, PRAPARE project
- ❖ Cliff and Measure 101 - will flip us back to where we were, we are concerned with this.
- ❖ Guidance on educating our staff and Board how to advocate.

## CCO CONNECTION(s):

NOT DISCUSSED

# Mosaic Medical

*Location(s): Bend, Redmond*

*SDH leads interviewed: Lindsay Stailing*

*APCM: √*

*Empathic Inquiry: √*

*EMR: OCHIN Epic*

*CCO(s): Pacific Source CCO*

## Population Health Equity (PHE) for APCM:

- ❖ Segmented populations not ID'd yet.
- ❖ Training held Oct 2017 for CHWs using PRAPARE, limited set of questions, financial security, food security and homeless status, practiced asking questions, between now and Nov 20th interview 5 patients through their normal process. Asking initially about financial security, expanding to housing and food if needs are identified.
- ❖ 2018 will start piloting tool at all sites. CHWs screening with the limited questions based on team warm handoffs to CHW along with a separate pilot for food security screening done on paper, entered by MA. Pts receive in the moment resources and are referred to CHW so they can follow up

## Screening/Workflow:

- ❖ Oct 10th and Nov 3rd trainings with CHWs (first on community resources, then on tool). Additional training on flexible services and legal aid services in Feb.
- ❖ Started systems-wide workgroup. Framed tool use. Quarterly - 1 hour of their time asked that they help identify screening strategies. Peds medical director, Med director at Bridge clinic, nutrition, nursing rep we are looking at, data analyst, Epic specialist, manager/behavioral health consultant, 2 CHWs, Therese and Lindsay. Also an NP doctoral candidate (will be doing a food insecurity pilot).

## Community Health Workers (CHWs):

- ❖ 10 CHWs - 1/2 have Bachelor's degrees. 1/2 have HS diploma or some education beyond HS.
- ❖ Quarterly team meetings.
- ❖ Main clinic sites have CHWs. 1 CHW supports rural school-based health centers
- ❖ CHWs are engaged in care team and may support some panel management (Depends on project & location).
- ❖ Can manage training CHWs in house. Been to the ORCHWA meetings, culturally imbedded not necessarily as relevant for primary care.
- ❖ Leveraging resources and training provided by THRIVE Central Oregon (model - Social Worker in the library).
- ❖ Scenario based practices are good.

## Community Partnerships:

- ❖ Did not discuss.

## Identified TA in 2018:

- ❖ Sample workflows!
- ❖ RD assessing for food insecurity...at what level do we use a behavioral health vs. CHW? Lots of clinical resources, not sure how to leverage.
- ❖ Patient support surveys.

### CCO CONNECTION(S):

- FUNDING FROM PACIFIC SOURCE FOR CHWs

# Yakima Valley Farm Workers Clinic (Rosewood)

*Location(s): Portland*

*SDH leads interviewed: Michelle Lehr O'Connell and Josie Riggall*

*APCM: √*

*Empathic Inquiry:*

*EMR: Epic*

*CCO(s): HealthShare / CareOregon*

## Population Health Equity (PHE) for APCM

- ❖ Full SDH screening for all new adult patients. Screening occurs during the first visit.
- ❖ Food insecurity questions have been built into the EMR and are asked annually for all adults.
- ❖ Rosewood is the test site for social determinants screening; the goal is to scale this to all clinics.
- ❖ Screening data is reviewed monthly.

## Screening/Workflow:

- ❖ Screening tool called: Wellness and Life Experience Survey. Includes questions on financial & housing security, stress, social isolation and trauma. Patients can indicate request for assistance.
- ❖ Screening during first visit is generally effective, but at times challenging because the relationship with care team has not yet been built.
- ❖ Screening tool is scanned into medical record upon completion.
- ❖ Intake RN identifies patients who screen positively and make referral to integrated provider (behavioral health consultant, dietitian, social worker, community health worker or psychiatric nurse practitioner).
- ❖ Providers and integrated providers update problem list with relevant Z code (codes for psychosocial barriers, including economic, housing and food insecurity).
- ❖ Z code in problem list enables PCPs to consider social determinants in patient visits and during care planning.

## Community Health Workers (CHWs):

- ❖ 2 community health workers, one focused on care management and resource coordination for the established patient and one focused on engaging patients who have been lost to follow up or have not yet established.

## Community Partnerships:

- ❖ Established partnerships and referrals to agencies providing the following services: inpatient and outpatient substance use treatment centers, shelters, housing, rental assistance, employment, domestic violence, maternity and baby services.

## Identified TA in 2018:

- ❖ OCHIN EMR work has dominated the OPCA learning space – can EMR support be provided for non-OCHIN systems?

### CCO CONNECTION(S):

- EXPLORING OPPORTUNITIES THROUGH NEW PARTNERSHIP WITH HEALTH SHARE / CARE OREGON.

## Key Takeaways on Social Determinant of Health Related Efforts at FQHCs in Oregon

- ❖ 19 of 32 community health centers in Oregon interviewed.
- ❖ 13 clinics have CHWs
  - Many CHCs deemed this possible as a result of APCM.
- ❖ 9 clinics involved in Empathic Inquiry learning collaborative during 2018.
- ❖ 10 clinics have a strong relationship with their CCO resulting in funding/support of upstream efforts.
- ❖ Clinics most engaged in this work include: Mosaic, Benton, Winding Waters, Rogue, YVFWC (Rosewood), La Clinica, and Rinehart.
- ❖ Recommendation for Oregon health centers:
  - Sharing best practices around data analysis: Mosaic, Rosewood, La Clinica.
  - Sharing best practices around data collection: Rosewood, La Clinica, Rogue, Winding Waters, Benton, Rinehart.
  - Sharing best practices around partnership development: Rogue and Coast.
  - Interested in onboarding to a consistent SDH workflow – Valley Family, Columbia River, LaPine, Mosaic.

**Contact for more information:**

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