Network Social Determinants of Health (SDH) Survey Results— Fall 2017

In September 2017, OPCA sent out a survey to the 32 Federally Qualified Health Centers in our membership across the state. The purpose of the survey was to gain understanding about: whether or not clinics are screening patients for social factors; if so, how they are screening; and what (if anything) is the data being used for. We received 55 responses from 25 health centers and thank each participant for the time in communicating the important feedback.

This data will be used to help OPCA target SDH-related support to our members in 2018.
Purpose:
Learn how CHCs in Oregon are assessing and addressing the SDoH in their patient population

Total Responses: 54
26 CHCs (includes OHSU Scappoose)

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.
Who took the survey?

Respondents by CHC role...

- Care Coordinator
- Social Worker
- Deputy Director
- Engagement and Communications
- Operations, 22%
- ED/CEO, 20%
- CMO/Medical Director, 13%
- Nursing, 2%
- Other, 7%
- Outreach & Enrollment, 4%
- Program Manager or Director, 13%
- Provider, 6%
- Quality, 9%
- Behavioral health, 4%
- Other, 7%
79% of survey responders said they track social and economic circumstances not included for the UDS.

69% of those tracking SDH data are capturing it in their EHR.
Clinics not tracking SDH data in their EHR are tracking the data in the following ways:

- **In paper format**
  - Hard copies

- **In spreadsheets**
  - Excel

- **Electronically**
  - Dot phrases
  - Data warehouse
  - Scanned hard copies
  - Notes in EHR section
What is social determinants of health data used for?

How CHCs are using SDH data...

SDH initiatives and programs
Social determinants screening tools used

- OCHIN SDH flowsheet, 16
- PRAPARE, 14
- ASSESS & DO, 4

Generally, the same tool!

Other, 11

- Accountable Health Communities grant, 4
- CCO initiatives
- Created own questions/forms
- Unsure
CHCs are assessing the following:

- Domestic violence: 92%
- Employment: 90%
- Stress: 92%
- Safety: 92%
- Transportation: 98%
- Material security: 98%
- Education: 89%
- Social isolation: 79%
- Refugee status: 67%
- Incarceration history: 63%

What CHCs said are relevant to screen for to improve population health.
Other SDH factors CHCs are assessing for...

- Homelessness/Housing
- Mental Health
- Occupation
- Gender Identity
- Trauma
- Legal Assistance
- Substance Abuse / Recovery
- Financial Assistance
Initiatives supporting CHCs to collect SDH data

Other Comments...
- IHN – CCO Delivery Systems Transformation Grant
- CCOs
- Clinic assessment and interests
- HRSA Grants – Transitions of Care
- None
- I don’t know
Social determinant initiatives and programs at CHCs

- Food Insecurity
- Referral & Resource Navigation
- Care Coordination & Management
- Employment Assistance
- OHP/SNAP Enrollment
- Financial Assistance
- Housing Insecurity
- Legal Assistance
- Safety
- Community Health Workers
- Transportation
- Peer Support Groups
- Outreach
Are you documenting social services or referrals patients receive?
SDH areas CHCs are interested in exploring

- Income
- Education
- Employment
- Sexuality
- Food Access
- Transportation
- Housing
- Air Quality
- Water Quality
- Safety and violence

[Bar chart showing the percentage of interest in each SDH area.]
Leading barriers to screening patients for SDH

- Staffing / Workflow implementation: 72%
- EMR / Technical implementation: 14%
- Lack of leadership support: 4%
- Other: 10%

- PRAPARE tool is cumbersome
- Getting all staff on board
- Uncertainty of what to do with the data
- Needing resources to send patients to
- Challenge of casting a wider net to ALL patients
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