Forum on Rural Population Health

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Seaside, Oregon
ohsu.edu/orhforum

OREGON OFFICE of RURAL HEALTH

Leveraging Community Partnerships to Support SDOH Needs for Patients Within the Healthcare Setting

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Agenda

- Background/Origins of the Model
- The Community Resource Desk Model – From Pilot to Statewide Program
- Leveraging Partnerships to Address Health Related Social Needs (HRSN)
- Using Data and Compliance Standards to Support Spread and Integration
- Funding and Other Considerations
- Q&A

Community Resource Desks
Responding to patients with HRSN
5 Oregon Counties

Background/Origins of the Model

What is a Community Resource Desk (CRD)?

The CRD program is a community service provided in partnership with and staffed by local social service non-profit organizations funded through Providence Community Benefit grant dollars.

Services Offered

- ✓ Clothing vouchers
- ✓ Bus passes
- ✓ Personal Care Panty
- ✓ Rental Assistance
- ✓ Energy Assistance
- ✓ Resource directories to organizations providing food, shelter and warmth
- ✓ Transportation through Providence

Community
RESOURCE DESK

Personal Care Pantry

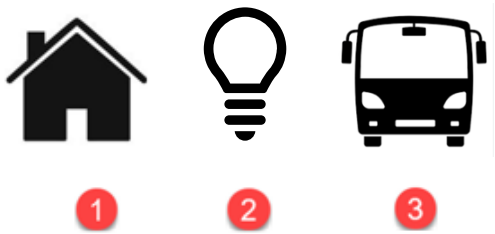
- Shampoo
- Bar Soap
- Deodorant
- Toothbrush and Toothpaste
- Razors,
- Shaving cream
- Hairbrush
- Dish Soap
- Household Cleaner
- Laundry Soap
- Toilet Paper
- Tampons/Pads
- Adult Depends
- Socks
- Sleeping bags
- Backpacks
- Ponchos
- Hats
- Light bulbs
- Baby wipes
- Baby Diapers
- Baby Bottles
- Children's books

Clatsop County CRD 2024 At-A-Glance

Processed 496 Referrals & served 434 Individuals, benefitting 651 in household

41% Epic Referrals & 45% Walk-Ups

707 resource needs identified



Top Needs were Housing, Utilities and Transportation

16% of clients served identified as people of color

56% were seniors 60+

89% of clients served had Medicaid or Medicare

Client Engagement and Support at the CRD

How does this work?

Norma Mota, CCA Resource Specialist

Who Can Use the Resource Desk Services?

The CRD is more than a service to our patients, and is open and available to anyone

- ✓ Non-patients are welcome too: friends, family, Providence staff or the community at large
- ✓ There are no eligibility requirements for the CRD, but most services connected to have income-based eligibility criteria

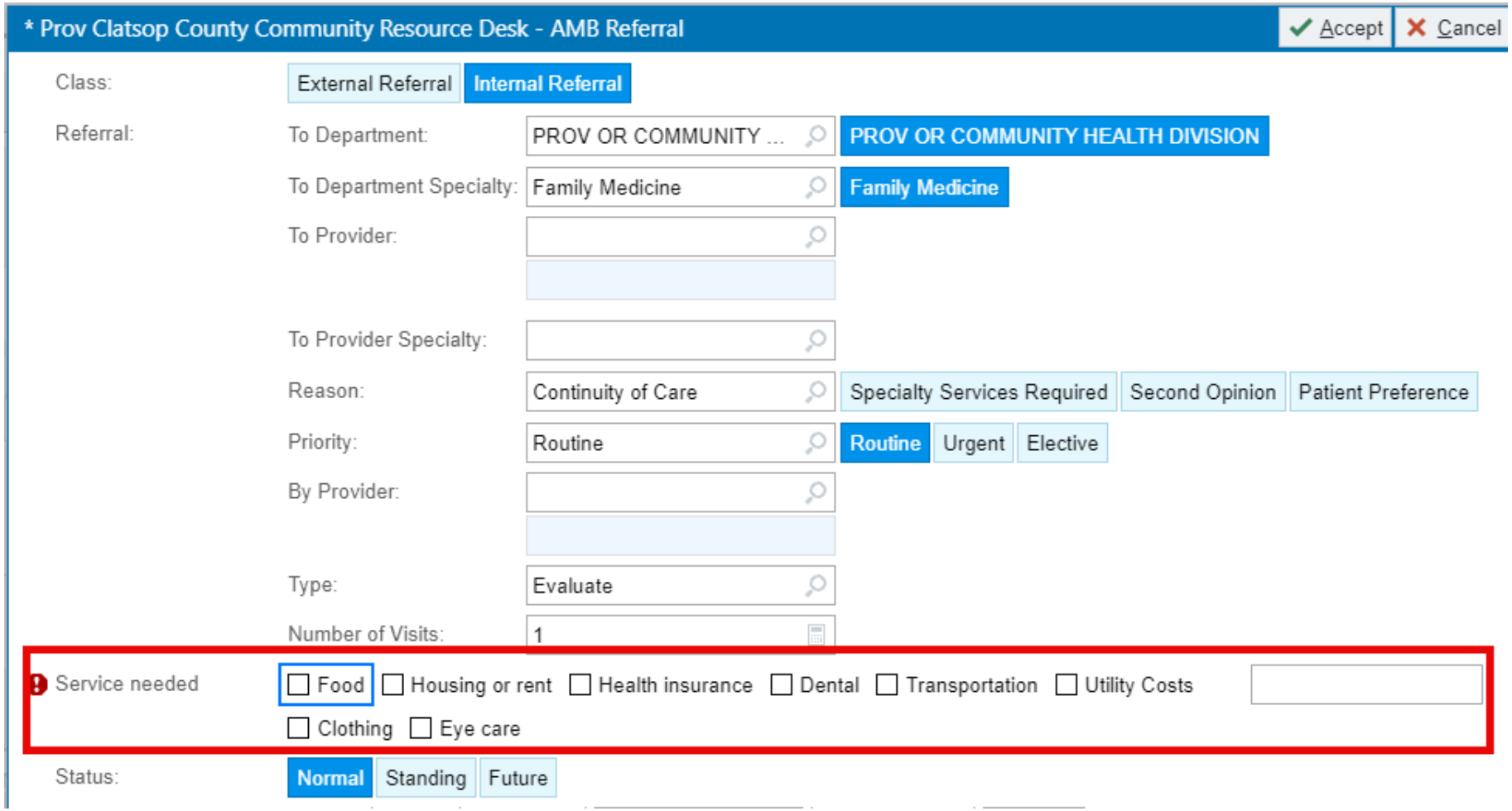
Individuals can self-refer or be referred by all staff, regardless of credentials:

- Epic referral *(available to ambulatory teams only)*
- Warm handoff via email, phone, text or Teams message
  - ✓ Encourage patients to contact CRD on their own
  - ✓ Walk someone over to the Desk or exam room consult if on-site

"We have a service available to patients and their families – the Community Resource Desk. Can I make a referral to them for you so they can support you with your social needs?"

Specialists are available Mon-Fri 7:30am-4:00pm
In-person availability - Monday through Friday in Seaside
3 days in Portland Metro and 4 days in Medford

Epic Referral Details



Epic Sample Note

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Notes

Delete | Print

Type	A..	Summary	User	Date	Time
Specialty Cor		Consult {More}	THOMPSON, SUZ	4/27/2021	01:24 PM PDT
Provider Com		Provider Comments		4/25/2021	07:47 PM PDT

Type: Specialty Comments

Consult: **Identified Needs:** Food

Resources: Spoke on phone with client. Specialist explained how to use Oregon Food Bank's food finder tool to search for food pantry locations and schedules, highlighting a couple that are near client's home and have frequent service. Texted link.

Barriers: NA

Follow Up Plan: Check in next week.

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From pilot to a statewide program:

CRD’s are now a pivotal component of our HRSN continuum of care

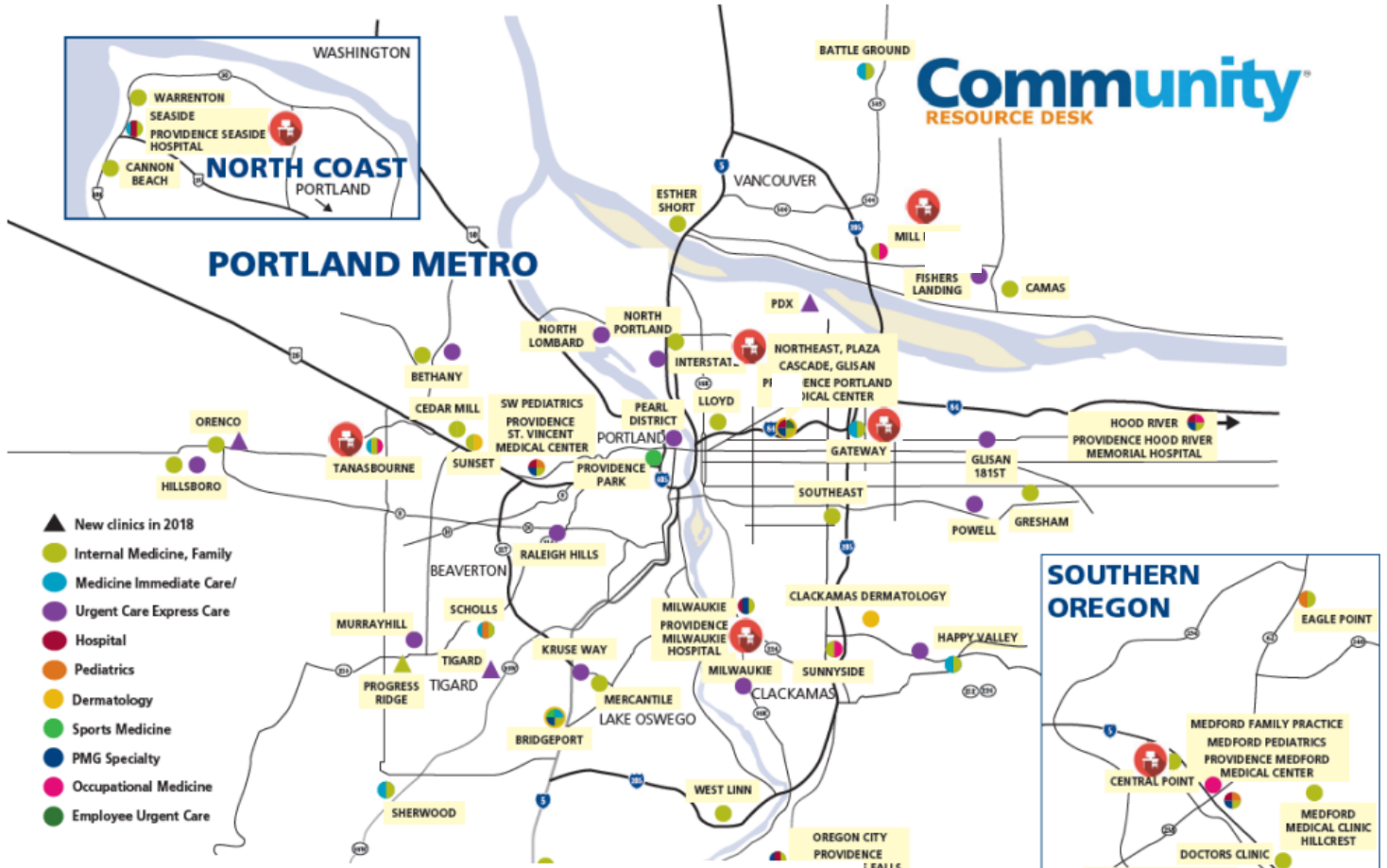
Community Resource Desk Partners

Our Partners:

- **Impact NW** for the Portland Service Area; Serving Multnomah, Clackamas and Washington County
- **Access** for Southern Oregon; Serving Jackson County
- **Clatsop Community Action** for the Oregon Coast; Serving Clatsop County

- Specialists are non-employee contractors employed through the community partners, not Providence employed caregivers
- Bilingual and bicultural
- Trained in person-centered service delivery & trauma-informed care

CRD Locations



Community RESOURCE DESK

Multnomah County
971-275-7157
Gateway Medical Plaza
1321 NE 99th Ave
Portland OR
Second floor lobby

Washington County
971-322-3003
Tanasbourne Health Center
10670 NE Cornell Rd
Hillsboro OR
Second floor lobby

Clackamas County
503-737-7390
Providence Healing Place
10330 SE 32nd Ave
Milwaukie OR
Second floor suite #205

Clatsop County
503-440-9118
Providence Seaside Hospital
725 S Wahanna Rd
Seaside OR
Hospital main entrance lobby

Jackson County
541-601-6793

Stewart Meadows Medical Plaza
70 Bower Dr
Medford OR
Second floor Sports Medicine lobby

Central Point Medical Plaza
870 S Front St
Central Point OR
First floor lobby

Community Resource Desk

PMG Oregon Social Needs Screening Data

SDOH PMG Clinic Screening Overview

Patients seen in a PMG primary care clinic in 2021-2023.

Screening rates include patients asked one of Housing, Food, Utilities, Transportation question in any Epic encounter within the same time period.

PMG Clinics: (All) | Geopod: (All) | Age Band: (All) | Date: (All) | Domain: (All) | Encounter Type: (Multiple values) | Language: (All) | Financial Class: (All) | Payor: (All) | Race: (All) | Ethnicity: (All) | Zip Code: (All)

Overview

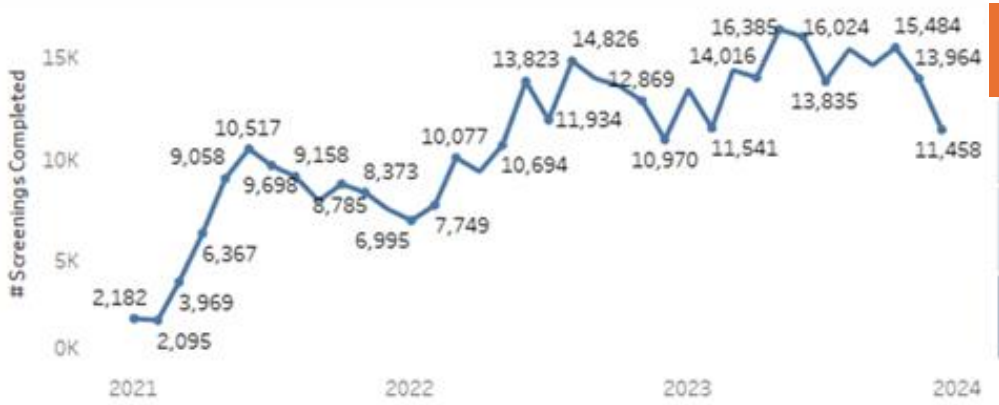
242,164
Patients Screened

57%
% Screened

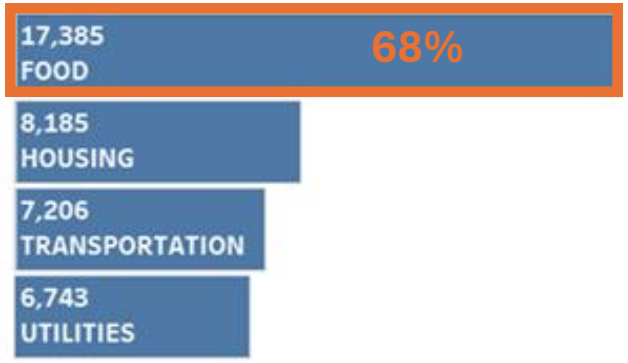
1.62
Average Screens Per Patient

25,390
Screened Positive

Number of Screenings Completed By Month



Patients By Need



Top 10 clinics with the highest number of positive food insecurity screens

		# Patients Seen	# Patients Screened	% Screened	Average Screens Per Patient	# Screened Positive	% Screened Positive
1	PMG GATEWAY FAMILY MEDICINE	13,312	13,312	100%	1.74	2,262	17%
2	PMG GATEWAY INTERNAL MEDICINE	6,304	6,304	100%	1.56	722	11%
3	PMG CLACKAMAS	8,688	8,688	100%	1.33	716	8%
4	PMG NORTH PORTLAND FAMILY MEDIC..	5,147	5,147	100%	1.44	693	13%
5	PMG THE PLAZA FAMILY MEDICINE	6,224	6,224	100%	1.28	585	9%
6	PMG MEDFORD PEDIATRICS	3,361	3,361	100%	1.43	580	17%
7	PMG NORTHEAST INTERNAL MEDICINE	4,044	4,044	100%	1.34	573	14%
8	PMG NEWBERG FAMILY MEDICINE	4,724	4,724	100%	1.18	511	11%
9	PMG GRESHAM	4,846	4,846	100%	1.85	510	11%
10	PMG AT ST VINCENT	4,734	4,734	100%	1.89	458	10%

Roles Supporting HRSN Response

- Community Resource Desks
- Community Health Workers
- Clinical Case Managers

  RN Care Managers
  LCSW's

Referrals are directed based on type of support requested, acuity, co-occurring mental/behavior needs or other conditions

CRD Service Areas – Monthly Caseload 2024

	Multnomah County*	Washington County	Clackamas County	Jackson County	Clatsop County
Average Epic Referrals per Month	417	181	126	85	16
Average Intakes per Month	287	104	61	52	36

***Note: Multnomah County has 2.0 FTE**

Partnering to Address Food Insecurity

Social Determinants of Health Screening at Providence Medical Group

Having access to food, transportation, and other basic supports affects a person's health. The questions below focus on these supports. Based on your responses, we can connect you with needed services. We are asking all of our patients to answer these questions. You are not required to complete this form.

1. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - ☐ Never true
   - ☐ Sometimes true
   - ☐ Often true

2. **Within the past 12 months the food you bought just didn't last and you didn't have money to get more.**
   - ☐ Never true
   - ☐ Sometimes true
   - ☐ Often true

3. **What is your living situation today?**
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but I am worried about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station or in a park)

4. **In the past 12 months, has the electric, gas, oil or water company threatened to shut off services in your home?**
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

5. **In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?**
   - ☐ Yes
   - ☐ No

6. **In the past 12 months, has lack of transportation kept you from meetings, work, or getting things needed for daily living?**
   - ☐ Yes
   - ☐ No

Please let us know if you would like assistance by selecting as many of the boxes below:

Hunger Vital Sign (Validated Screening Tool)

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ACCESS BUILDING COMMUNITY

Providence Gateway Food Pantry

Located in NE Portland

- Satellite of **Portland Open Bible Community Pantry** (OFB Network)
- Serves two high need primary care clinics
- Serves on average 6-8 patients/households per day
- "Shopping model" pantry visits facilitated by community resources specialists who provide ongoing food resources

SERVING THE COMMUNITY

- Pantry is open to all community members
  - Up to 300% of federal poverty level
  - Jackson County resident

- Clients leave with a 3–4-day supply of food
  - Shelf stable – canned
  - Produce
  - Baked goods
  - Frozen meat
  - Dairy
  - Also – hygiene items

Providence

ACCESS
BUILDING COMMUNITY

Community Partnerships:

HRSN Compliance
Funding Considerations

Regulatory Requirements for Screening

Joint Commission

- Effective 1/1/23
- **Domain**: Screen for 1 domain- to be selected by health setting (financial resource strain)
- **Patients**: Identified population of choice by health setting (all admitted patients)
- **Who/where**: The workflow to satisfy TJC is the same as the inpatient CMS screening.
  - *If need talking points on why there was a change this can be provided*

CMS

- Effective 1/1/24
- **Domains**: Screen for 5 domains (CMS allows starting with 1 cascading question)
  - Housing
  - Transportation
  - Food Insecurity
  - Utilities
  - Safety/violence
- **Patients**: All admitted adults 18+
- **Who Screens**: Acute Nursing at Admit Arrival
- **Positive Screen Workflow**: Refer to IP SW
- **Owner**: Sarah Power and Mike Dahlen

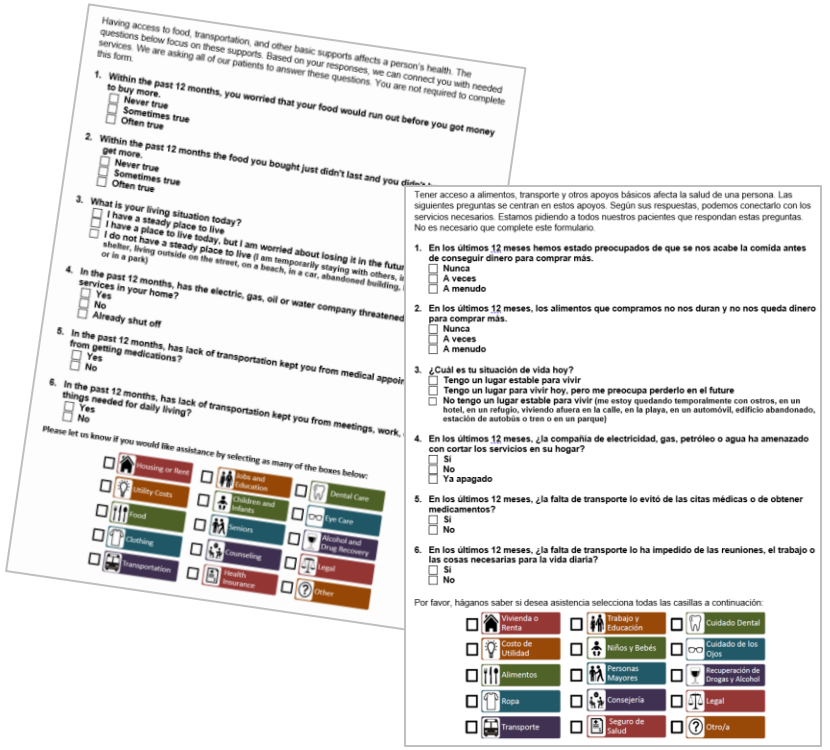
OHA

- Effective 1/1/23; reporting 1/26
- **Domains**: Screen for 3 domains
  - Housing
  - Food
  - Transportation
- **Patients**: All Medicaid patients/members in primary care (adults and children)
- **Who Screens:** PMG MAs or PSSs
- **Where in Epic:** History section
- **Positive Screen Workflow:** CRD or PMG Care Management
- **Owner:** PMG SDOH Workgroup led by Rachelle Favorel

SDOH requirements only require screening now, but have glide paths to report on # referrals and connection rates

OHA SDOH Measure Overview
Social Needs Screening & Referral Measure

- **This measure aims to acknowledge and address OHP members' social needs over the course of three years**
  - **Component 1:** 2023 – 2025: Assesses CCO's plans for implementation of social needs screening and referral in an equitable and trauma-informed manner; ensures groundwork is laid for data sharing and reporting.
  - **Component 2:** Measurement years 2025 – 2026: Measures the percentage of CCO members screened and, as appropriate, referred to services.



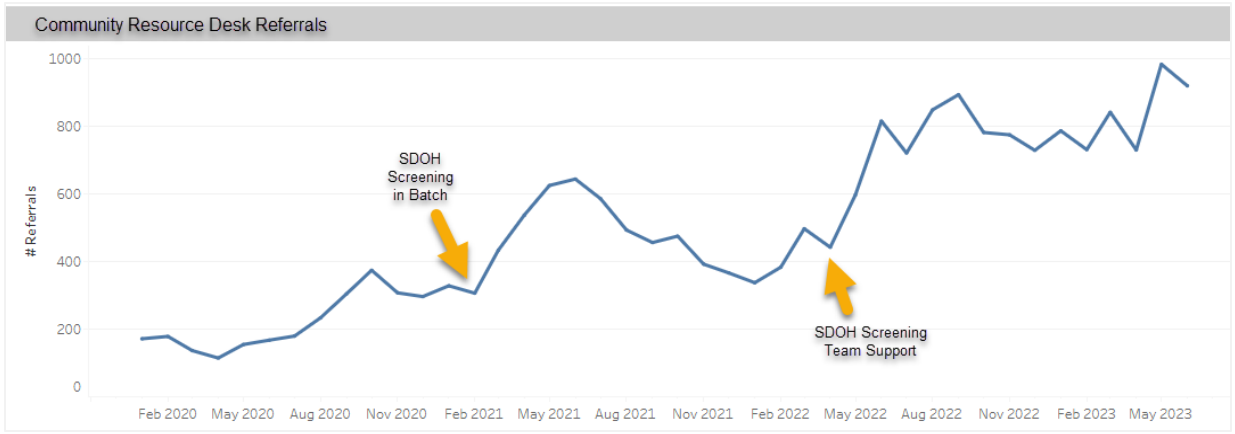
Using Data to Inform Partnerships and Justify Funding

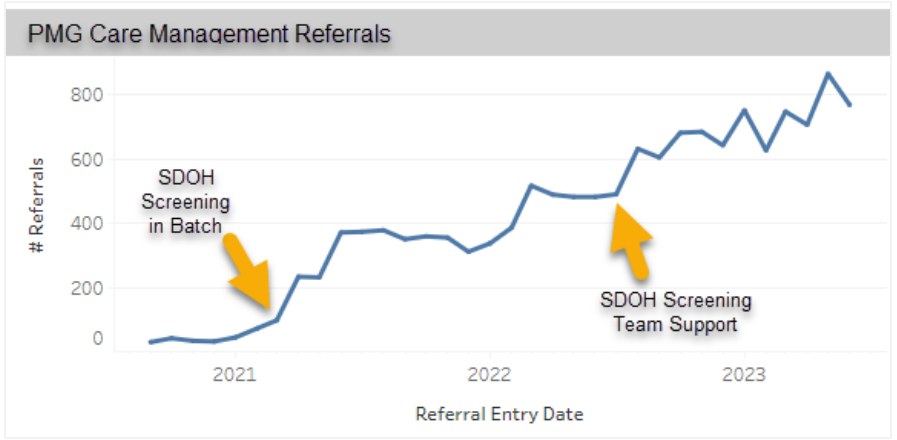
In 2024, Providence Oregon screened nearly 200,000 unduplicated patients across payers in ambulatory, acute and home & community care settings.

- 12% positive rate across all settings
- Goes up to 27% among Medicaid patients

PMG alone screened 131,096 patients and sent 17,085 referrals to the Community Resource Desk or PMG Care Management

- 7,650 of those referrals were for a Medicaid member (38%)
- Medicaid members accounted for 44% of all CRD referrals
- In the Portland Metro Area - 9,475 CRD referrals went to 4.5 staff





Funding

- Primarily Funded by Community Benefit
- Goal is to move to braided funding
- Pursuing billing and reimbursement for Medicaid
- Supporting our CBO partners to contract with CCO’s as HRSN service providers

Clatsop Community Action

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Thank You!

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Thank you to the 2025 Forum partners!

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