

## ASHER COMMUNITY HEALTH CENTER Social Determinants of Health Efforts

Efforts to improve health across the country have often looked to clinical settings and health care as the key driver of health and health outcomes. Increasingly, it is recognized that improving health and achieving health equity will require approaches beyond medical attention that move “upstream” to address social, economic, and environmental factors that influence health. Our health center is actively working to better understand and address the social determinants of health that impact our patients and our communities.

### ABOUT US

The Mission of the Asher Community Health Center is to provide high quality primary health care, preventative health care, and dental care in Wheeler County, Oregon, regardless of a patient's ability to pay. Well coordinated primary health, behavioral health, oral health, home health, public health, and social services helps people to improve health habits, maintain wellness, recover from brief periods of illness and injury, and cope with chronic disease states.

It is our intent to make this health care system available to local residents and visitors by:

- \* Coordinating with local service providers;
- \* Reducing barriers to access;
- \* Providing active public education and outreach.

*Understanding our patients' needs as gleaned from our Social Determinants of Health data will allow us to best focus our efforts, and to have the most profound effect for our populace.*



### Screening for Social Needs

Asher Community Health Center uses PRAPARE, a national screening tool and approach to collect standardized social needs data to better understand the patients' social needs and transform their care. PRAPARE consists of a set of national core measures as well as a set of optional measures for community priorities. It was informed by research, the experience of existing social risk assessments, and stakeholder engagement. It aligns with national initiatives prioritizing social determinants (e.g., Healthy People 2020), measures proposed under the next stage of Meaningful Use, clinical coding under ICD-10, and health centers' Uniform Data System (UDS). For more information on PRAPARE, visit [www.nachc.org/prapare](http://www.nachc.org/prapare)

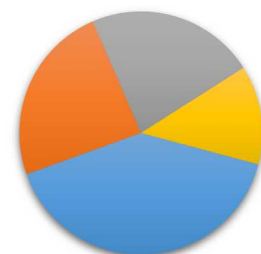
Asher CHC is still in the process-development stage of gathering SDH data. In the previous 12 months, 102 patients have been screened with PRAPARE. We are currently learning how to create reports to give us focused information we can utilize.

### UNDERSTANDING OUR PATIENTS' SOCIAL NEEDS

Based on our screening efforts using the PRAPARE tool, we have found that the most common social risks for our patients are:

1. *Financial Strain – Positive response in 52% of the patients screened*
2. *Housing Insecurity – Positive Response in 31% of the patients screened*
3. *Food Insecurity – Positive response in 29% of the patients screened*
4. *Stress – Positive Response in 17% of the patients screened*

Percentage of Screened Patients  
Experiencing Social Needs



■ Financial ■ Housing ■ Food ■ Stress



## UNDERSTANDING OUR PATIENTS' SOCIAL NEEDS

### HOW OUR HEALTH CENTER IS RESPONDING TO OUR PATIENT'S SOCIAL NEEDS

Within the ACHC patients we've screened in the last 12 months, 29% indicated they experience Food Insecurity.

Our clinic, Asher Community Health Center (ACHC), as a partner with our local Wheeler County Local Community Advisory Council (WC LCAC), collaborate on a new program: "Frontier Veggie RX".

From May-September 2019, there were 534 individuals served (279 households) throughout Wheeler County residents. The planned 'doses' over 11 months are 862.

Economically, this means the total Fruit and Veggie value:  $862 \times \$30 = \$25,860$   
That is: \$25,860 dollars spent supporting local business and encouraging healthy eating habits!

The LCAC and Clinic partnership will be taking on new layers as Frontier Veggie RX recipients will soon be monitoring weight (BMI) and blood pressure by visiting one of the three local ACHC clinics.

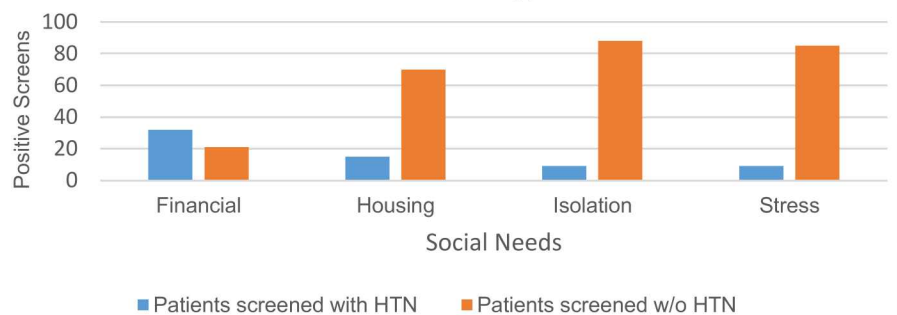


### SDH and HTN

The following compares our ACHC patients with Hypertension (HTN), and their responses for 4 of the Social Determinants of Health (SDH) screenings.

- 102 patients screened for SDH needs in last 12 months
- Of those 102, those also diagnosed as having HTN
  - 33% positive for Financial Strain
  - 15% positive for Housing Insecurity
  - 9% positive for Social Isolation
  - 9% positive for Stress Risk

### Social Determinants of Health and Hypertension



Bringing higher level screening and care to our patients, right where they live. (March 2019)

### WHY WE BELIEVE IN THIS WORK

Utilizing the framework of social determinants of health (SDH) helps us to be effective by understanding a more complete picture. With SDH, it becomes easier to recognize the value of economic conditions and demography as essential to staying healthy. Our goal is to increase patients' preventive healthcare, reduce preventable emergency department visits, and to help patients gain more ownership and control over their personal health and wellness. With our Tele-Health, communitywide health events and programs, and Community Health Worker program – we are making progress toward these goals and achieving measurable results. We're striving to meet our patients' physical, behavioral, social, and economic needs right where they are—to bringing resources to them where they live. We believe in the wisdom of aging in place as "the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level". Our programs are deliberately designed to help our frontier rural residents age in place with dignity and respect.

Understanding patient's social needs is at the foundation of the health center movement. Community health centers came out of the War on Poverty in the 1960's and since then, have strived to provide whole person care by creating space to discuss and address needs well beyond the medical visit. Yet this work takes staff time, resources, and space to ensure it is done thoughtfully. That's why Asher Community Health Center is proud to share this work with OPCA and consider opportunities for alignment.

Please reach out to Susan at ACHC: 541-763-2725.