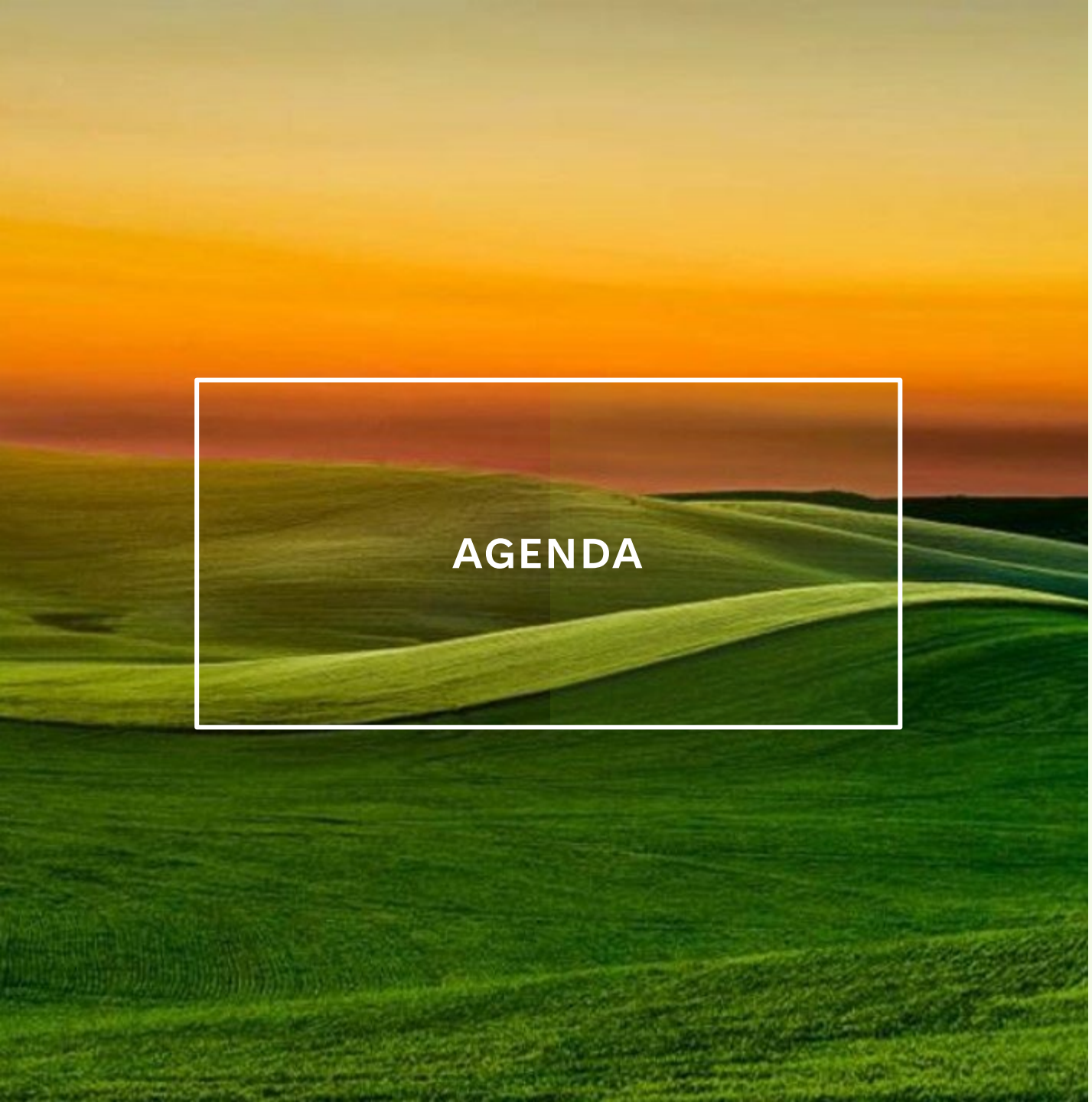
COLUMBIA COUNTY HEALTH SYSTEM *SOCIAL DETERMINANTS* REFERRAL PROGRAM

Connecting patients with community resources to address social needs outside of the primary care environment.

Melissa Peterson
Washington State University
Columbia County Health System



AGENDA

The “Original Plan”

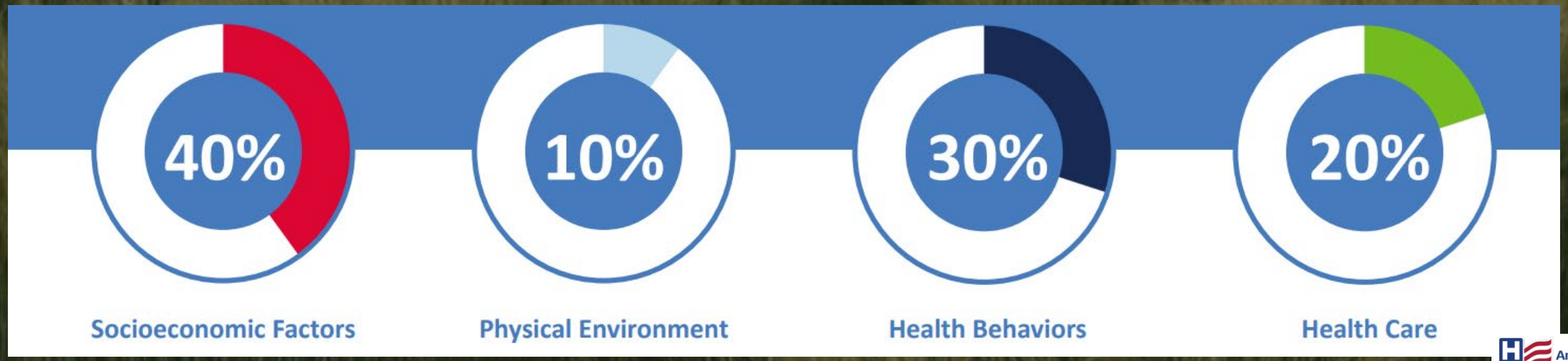
Events

Lessons Learned

THE POWER OF CONNECTING

Exploring Primary Care's Role In Health Disparity and SDOH

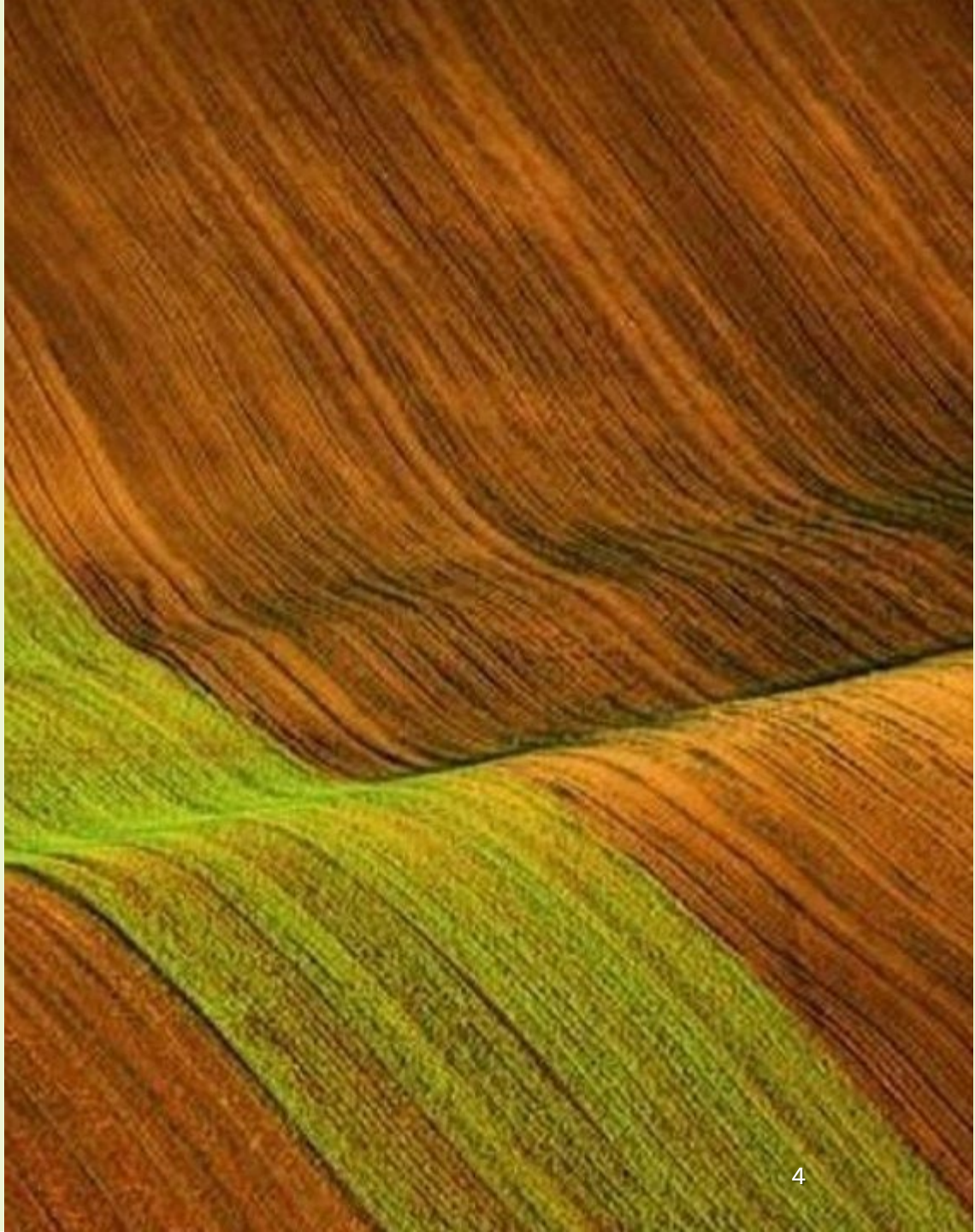
Let's make it personal



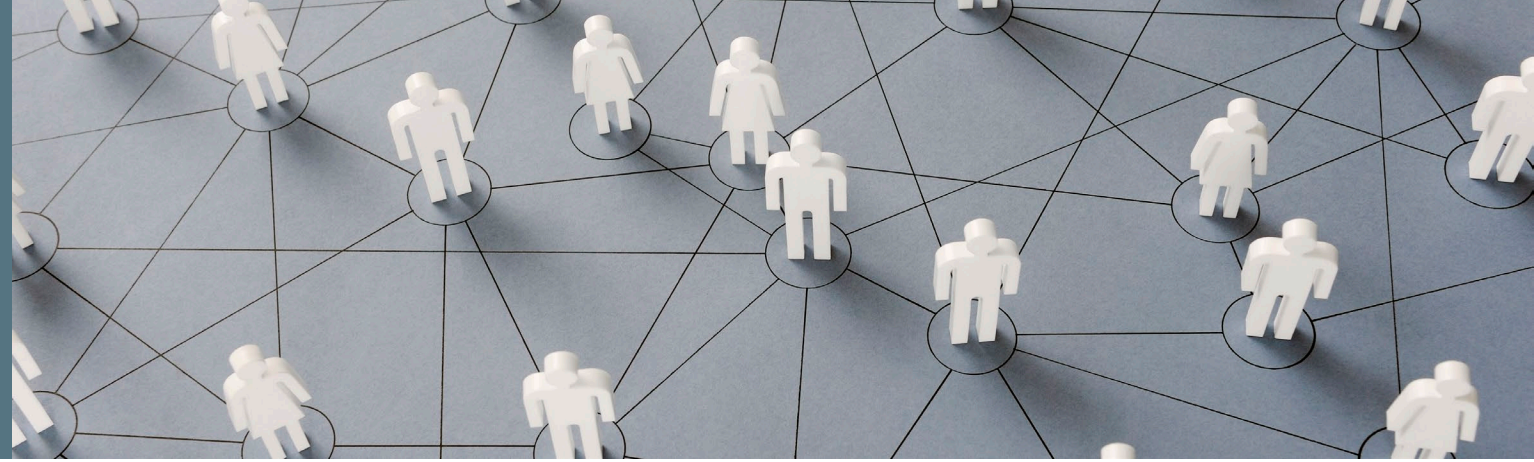
American Hospital Association™

Advancing Health in America

THE “ORIGINAL PLAN”



ASSESSING CURRENT RESOURCES AND WORKFLOWS



Population Health Program

- Palliative Care
- Chronic Care Management
- Community Health Workers
- Partners Improving Patient Health (Disease Management, COPD/Cardiovascular Disease)
- Diabetic Education

CCPH	Project Timothy	Food Bank	GHN
WIC STI Prevention, education and monitoring Children with disabilities services	Food Housing Supplies	Food (weekly)	Hub Portal CHW SE Washington Community Resources

EVENTS

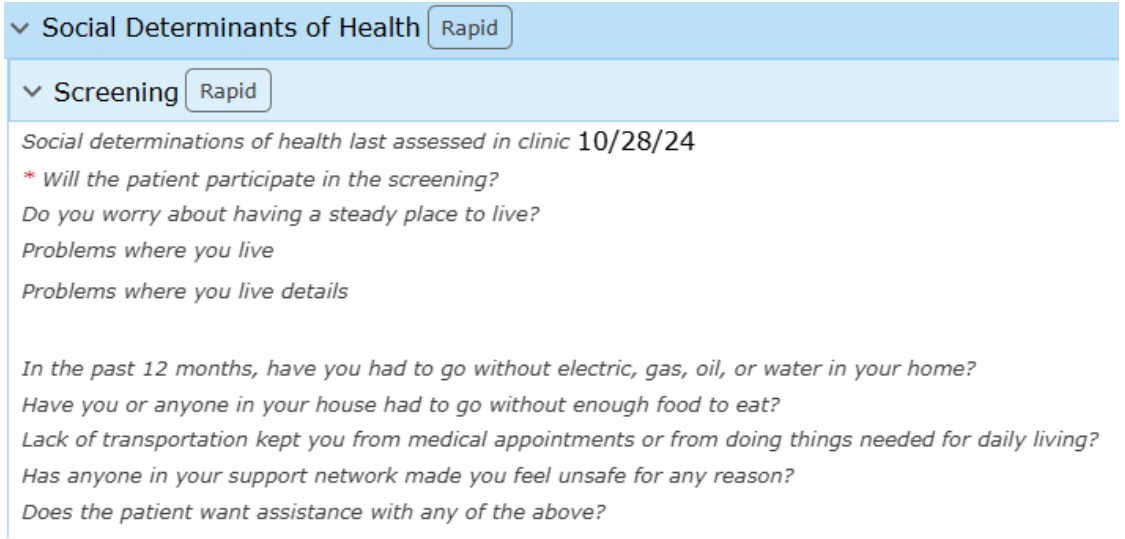
PROBLEM SOLVING

Electronic Medical Record

- Screening not streamlined (PRAPARE)
- Registries not working
- Referral Process

Community Resources

- No communication
- Limited Services
- GHN Timeline for HUB accessibility
- Systems



REGISTRY EXAMPLE ONE

SDOH Last Screened		Health related social needs		CHW Interventions	Additional HRSNs	Patient requested assistance	
		Food insecurity	(126)			Y	(126)
06/18/25	(6)	Inadequate housing	(106)			Y	(6)
		Material hardship	(236)				
		Material hardship	(179)				
04/15/25	(12)	Material hardship	(109)			Y	(70)

REGISTRY EXAMPLE TWO

Worry about housing		Living condition problems		Utility difficulties		Worry about food		lack reliable transportation		Unsafe at home	
No	(13)	no known problems	(13)	No	(13)	No	(13)	No	(13)	No	(13)
No	(20)	no known problems	(20)	No	(20)	No	(20)	No	(20)	No	(20)
No	(76)	no known problems	(76)	No	(76)	No	(76)	No	(76)	No	(76)
No	(21)	no known problems	(21)	No	(21)	No	(21)	No	(21)	No	(21)
Yes	(34)	<Multiple>	(34)	No	(34)	Yes	(34)	Yes	(34)	No	(34)
No	(35)	no known problems	(35)	No	(35)	No	(35)	No	(35)	No	(35)

Z CODES

TRACKING OUR PATIENTS AND TRENDS

Social Determinants of Health Rapid

Screening Rapid

- *In the past 12 months, have you had to go without electric, gas, oil, or water in your home?* Yes
- *Have you or anyone in your house had to go without enough food to eat?* Yes
- *Lack of transportation kept you from medical appointments or from doing things needed for daily living?* No
- *Has anyone in your support network made you feel unsafe for any reason?* No

Does the patient want assistance with any of the above? Yes

Social Determinants of Health Comments (SDOH details)

Health Related Social Needs Rapid

Health related social needs

Food insecurity (Z59.41) | Housing instability, housed, with risk of homelessness (Z59.811) | In

Material hardship (utilities) (Z59.87) | Problem related to primary support group (Z63.9)

Transportation insecurity (Z59.82)

Health related social needs details

IN OUR CORNER

Population Health Team

- Instant Buy In
- Already in the field
- SDOH Knowledge
- Provider Champion

Buy In From Clinical Team

- Familiar with screening tool
- Workflow outlined clearly
- Minimal workflow change on the front end

LESSONS LEARNED

WINS AND CHALLENGES

WINS

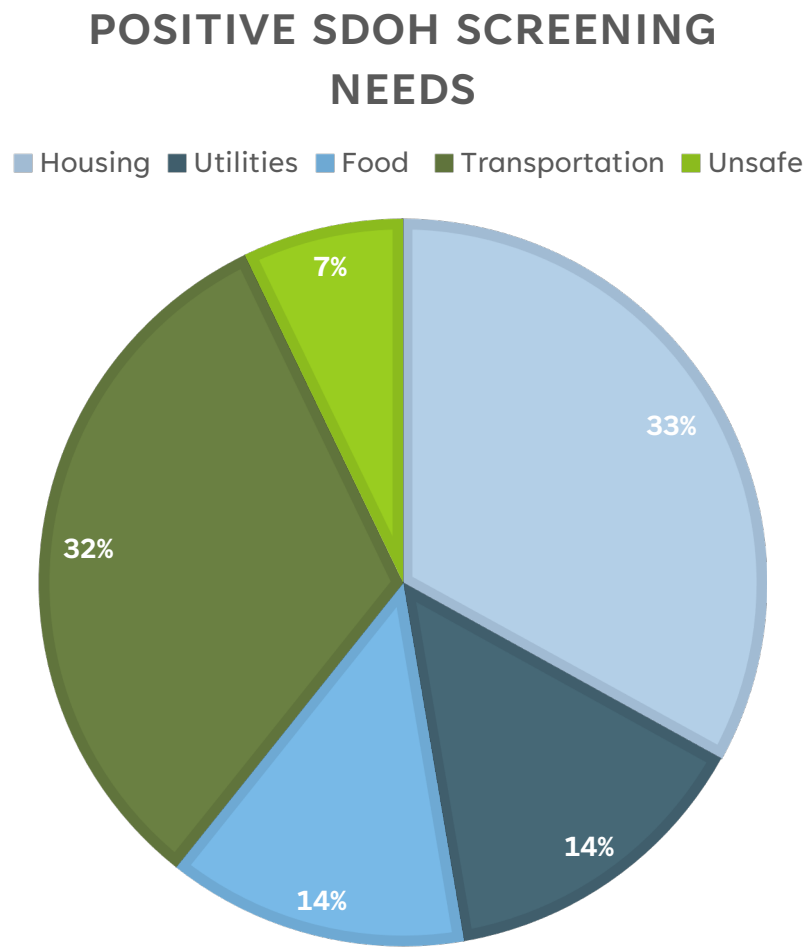
- 90% success rate screening patients for SDOH in the first week.
- 100% success rate with appropriate provider referrals to CHW team.
- Continued conversations with GHN for Community Hub enrollment.
- Team buy-in.
- Organization – training - education

CHALLENGES

- System (EMR) failure
- Lack of referral “system” for community resources.
- Heavy pull for Population Health team.
- Insecure sustainability.
- The literature studies may be right?
    - Will we be the change?

PROGRESS SINCE APRIL 10th, 2025

SERVICES	NUMBER
SDOH SCREENINGS	713
REFERRALS	37



THANK YOU

QUESTIONS?

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