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A Resource Center for Today's Case Manager

Social Determinants of Health: Connecting to Community Resources

Jessicca Moore, MSN, FNP
Director of Innovation
Petaluma Health Center

MaryBeth Kurland, CAE
Chief Executive Officer
Commission for Case Manager Certification

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Agenda

- Welcome and Introductions
- Learning Outcomes
- Presentation:
  - **Jessicca Moore,** MSN, FNP,
    Director of Innovation , Petaluma Health Center
  - **MaryBeth Kurland, CAE**
    CEO, CCMC
- Question and Answer Session

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Audience Notes

- There is no call-in number for today's event. Audio is by streaming only. Please use your computer speakers, or you may prefer to use headphones. There is a troubleshooting guide in the tab to the left of your screen. Please refresh your screen if slides don't appear to advance.

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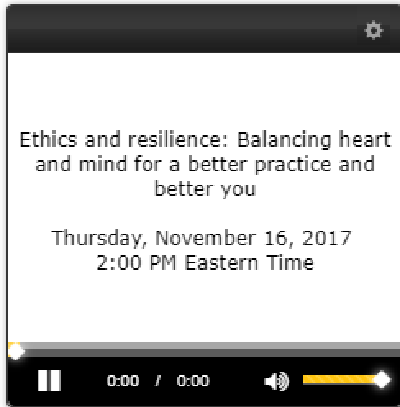

How to submit a question

To submit a question, click on Ask Question to display the Ask Question box. Type your question in the Ask Question box and submit. We will answer as many questions as time permits.

Ask Question

Submit

Click here

Materials

Ask Question

Audience Notes

- A recording of today's session will be posted within one week to the Commission's website, www.ccmcertification.org
- One CCM continuing education ethics credit for board-certified case managers (CCM) and one ANCC nursing contact hour continuing education credit is available for today's webinar only to those who registered in advance and are participating today.

Learning Outcomes Overview

After the webinar, participants will be able to:

1. Demonstrate effective strategies for implementing social determinants of health screening in primary care.
2. Analyze ways to leverage technology and data to better address patient's identified social determinants of health.
3. Evaluate current community partnerships and identify ways to expand these key relationships and grow new partnerships.

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PACE™

CareManagement

Your zip code impacts your health

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Could where you live influence ***how long you live?***

People living just a few blocks apart may have vastly different opportunities to live a long life in part because of their neighborhood. Unfortunately, significant gaps in life expectancy persist across many United States cities, towns, ZIP codes and neighborhoods. The latest estimates of life expectancy reveal differences down to the census tract level. Explore how life expectancy in America compares with life expectancy in your area, and resources to help everyone have the opportunity to live a longer, healthier life.

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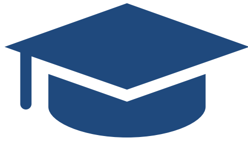
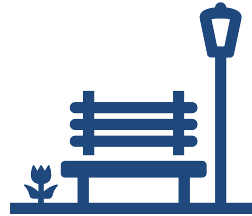
Social factors that affect health

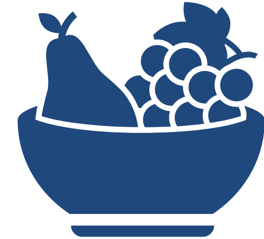
Individual behavior + social factors account for **60%** of mortality risk



Education



Community



Food

Economic Stability

Neighborhood and Physical Environment

Health Care System

Source: Schroeder, SA (2007). We Can Do Better—Improving the Health of the American People. NEJM 357:1221-8

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Jessicca Moore, MSN, FNP

Director of Innovation

Petaluma Health Center

Petaluma HealthCenter

Petaluma Health Center

- **Location**: Two primary care sites with 2 school based health sites and 1 homeless shelter site
  - Petaluma & Rohnert Park, CA
- **EHR Used**: eCW
- **Unique Patients**: 35,000
- **Population:** 50% Medi-Cal, 15% Medicare
  - ~40% Monolingual Spanish Speaking

Why SDOH?

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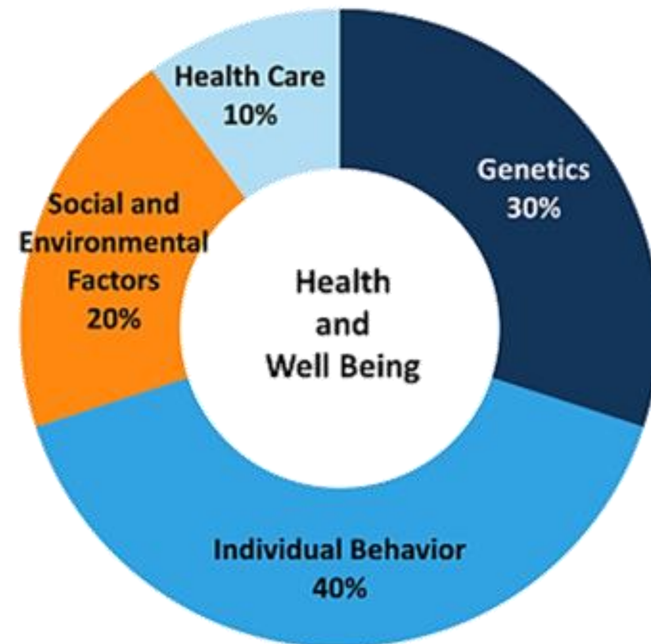
- Social determinants of health are *"the structural determinants and conditions in which people are born, grow, live, work and age."*
- There is growing recognition that a broad range of social, economic, and environmental factors shape individuals' opportunities and barriers to engage in healthy behaviors.
- National focus on collecting SDOH data and addressing social needs.

Impact of Different Factors on Risk of Premature Death



Source: Schroeder, SA (2007). We Can Do Better—Improving the Health of the American People. NEJM 357:1221-8

KFF

The Problem

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- Fear of Overwhelm→ What can we do?
- No Standard Screening→ Needs Not Identified
- Community Resource Information Not Widely Available or Current

Where to Start?

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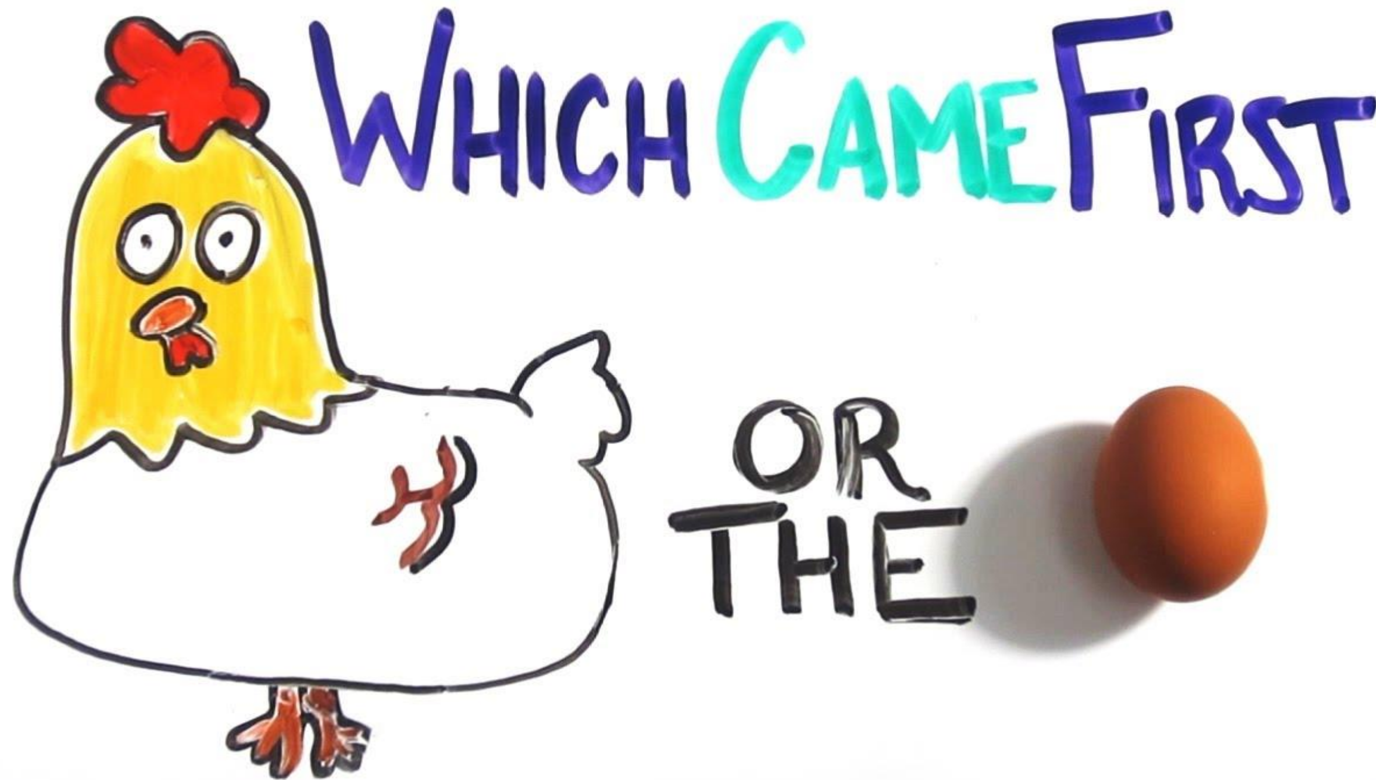

Addressing SDOH in 21st Century

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Physical Binder → Virtual Binder

Platforms

Petaluma Health Center

- Healthify
- Purple Binder
- One Degree
- Aunt Bertha
- Health Leads
- Now Pow

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26,767

PEOPLE USE IT

(and growing daily)

Standardizing Data Collection

- **PRAPARE:** *Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences*
- PRAPARE is a **national effort** to help health centers collect data on their patients' SDOH.
- National core measures as well as a set of optional measures for community priorities
- In addition to a paper document, EHR templates exist for **eClinicalWorks**, **Epic**, GE Centricity, and **NextGen**

Screening: PRAPARE

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WHAT IS PRAPARE?

Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences:

A *national standardized patient risk assessment protocol* designed to engage patients in assessing & addressing social determinants of health (SDH).

PRAPARE = SDH screening tool + implementation/action process

Customizable Implementation and Action Approach

Assess Needs

Respond to Needs

At the Patient and Population Level

Screening: PRAPARE

Core

UDS SDH Domains	Non-UDS SDH Domains
1. Race	1. Education
2. Ethnicity	2. Employment
3. Veteran Status	3. Material Security
4. Farmworker Status	4. Social Integration
5. English Proficiency	5. Stress
6. Income	
7. Insurance	
8. Neighborhood	
9. Housing	

Optional

Non-UDS SDH Domains

1. Incarceration History
2. Transportation
3. Refugee Status
4. Country of Origin
5. Safety
6. Domestic Violence

PRAPARE asks 15 questions to assess 14 core SDH domains.

- 9 questions already asked for UDS reporting
- 5 non-UDS questions informed by MU3

PRAPARE has 6 optional domains

Screening Strategy

Care Gaps

Due for PRAPARE
Recommended Intervention: Give Patient PRAPARE Screening Today

Not Web-Enabled
Recommended Intervention: Web Enable Patient Today

Due for Colorectal Cancer Screening
Recommended Intervention: Order Colonoscopy or Fit Kit Today

Due for Mammogram
Recommended Intervention: Order Mammogram

Due for Hepatitis C Screening
Recommended Intervention: Order Hep C Screening Lab Today

Overdue for cervical cancer screening (F24-64 excludes hysterectomy)
Recommended Intervention: Urge Patient to get PAP TODAY

- Part of Clinical Decision Support
- Risk score > or = 3
- Diagnosis of Diabetes or Depression

Using Data to Inform Partnerships

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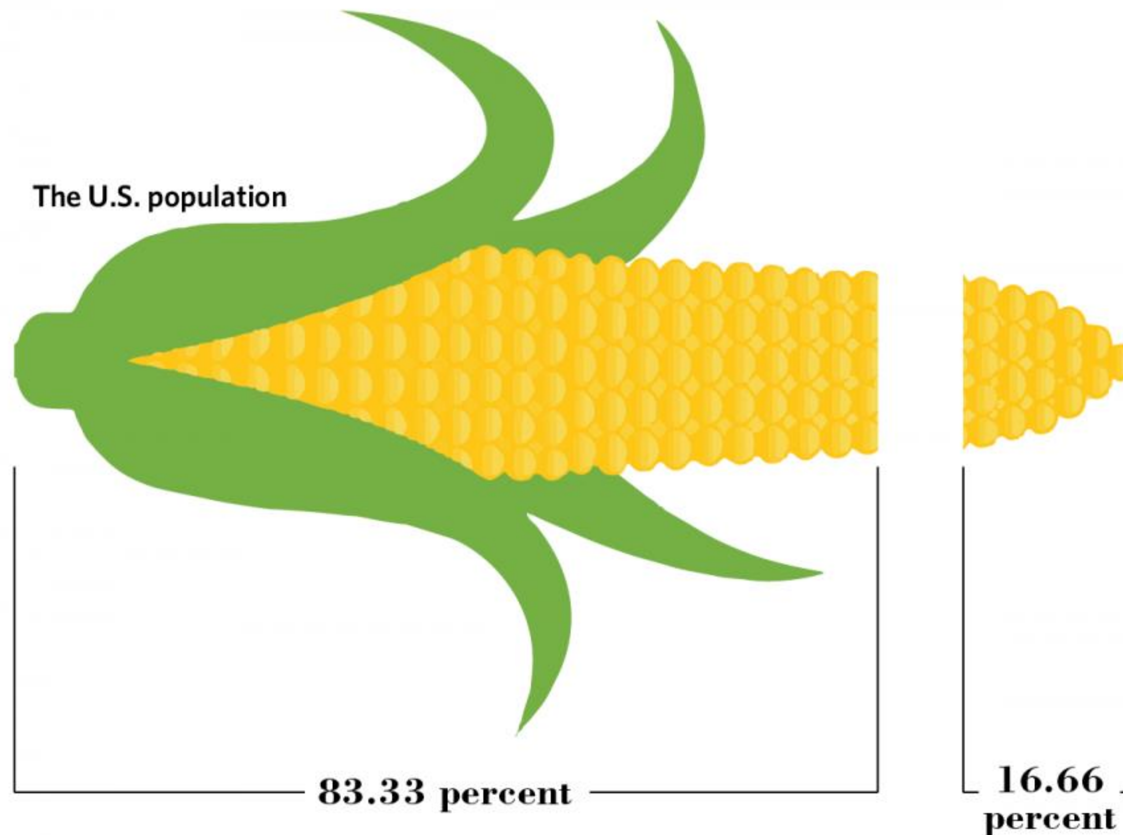
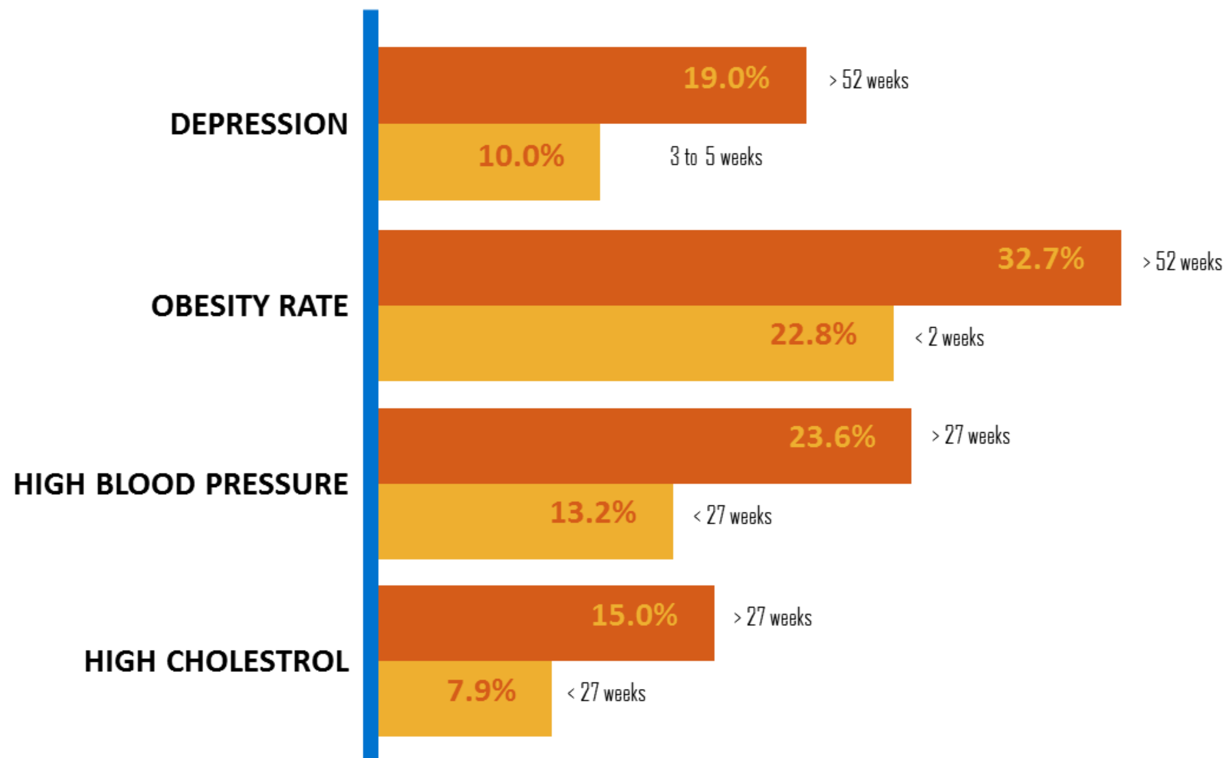


Using Data to Inform Partnerships



Food First

Petaluma Health Center

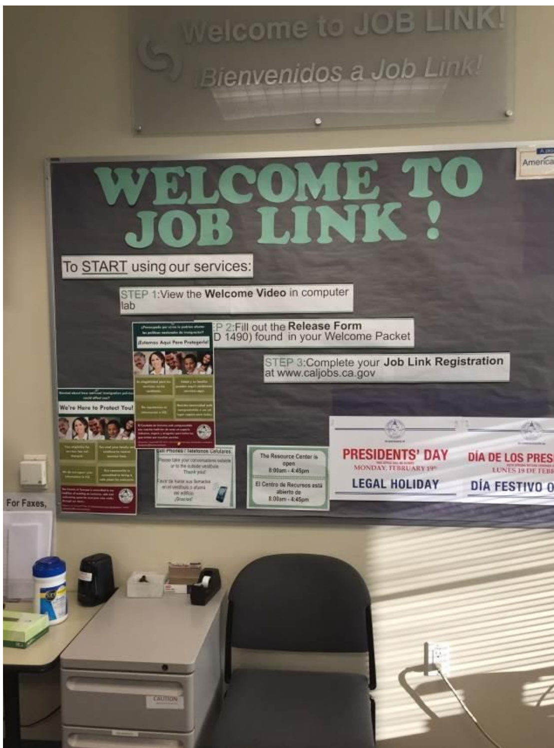
Petaluma Bounty

Redwood Empire Food Bank

Employment and Skills

Petaluma Health Center

Sonoma County Job Link   Petaluma Adult School



Lessons Learned

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- You don't know until you ask. This goes for screening patients as well as mutually beneficial partnerships.
- Front line staff who are doing the work need to be at the table from the beginning.
- Engaged leadership will help you move this work forward faster. Evaluate priorities before launching.
- Look for opportunities for pilots and seed funding, lots of energy and interest in this field.
- Partnerships take time.
- This is community building work.
  - Get outside of your four walls!

CONTACT INFORMATION

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Question and Answer Session

Jessicca Moore, MSN, FNP
Director of Innovation
Petaluma Health Center

Thank you!

- Please fill out the survey after today's session
- Those who signed up for continuing education will receive an evaluation from the Commission.
- A recording of today's webinar and slides will be available in one week at http://ccmcertification.org

Commission for Case Manager Certification

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