ASSESSING & ADDRESSING SOCIAL NEEDS: LESSONS LEARNED IN EARLY IMPLEMENTATION

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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?

• 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.

Figure 1
Impact of Different Factors on Risk of Premature Death

The Problem

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

Which came first, or the other way around?
Addressing SDOH in 21st Century

Physical Binder → Virtual Binder

- Purple Binder = an online community resource directory and closed loop referral system.
Successes & Challenges

- Vendor fully resourced the community and updated directory every 6 months
- Included a closed loop referral system
- Ability to print, email, or text resources to patients
- Users could create favorite resource lists
- Utilization reports were easily accessible

- No option for health center “single sign on”
- Product couldn’t integrate with EHR
- Lack of public facing website
- No integrated SDOH questionnaire to drive referrals
- Unable to upload patient flat files
Platforms

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

Type in a keyword like TRANSPORTATION, HOUSING, or FOOD to find resources in your ZIP code.

Find (Options):
Food pantry, rent, etc.

Available in:
Austin, TX or 78701

Q, Search

We serve individuals in and around Marin, Napa, Sonoma, and Yolo Counties.
Get involved: Suggest a program that isn't already listed, or claim a program you work for.

Single Sign-On
Public Facing Website
Closed Loop Referral Possible
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

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

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

- Part of Clinical Decision Support
- Risk score ≥ 3 initially, then decreased to 2 or above
- Diagnosis of Diabetes or Depression

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
Screening Rates

PRAPARE - Social Determinants of Health

**COMPLIANCE**

22%

\[
\frac{4,606}{20,902}
\]

0 exclusions

**TARGET**

7

Compliance is 7 percentage points above the organization's target of 15%.

Compliance trend
Using Data to Inform Partnerships

Food insecurity nationally
Nationally, 1 in 6 adults have inadequate access to enough food.

The U.S. population

83.33 percent

16.66 percent

EFFECTS OF LONG-TERM UNEMPLOYMENT

<table>
<thead>
<tr>
<th>Condition</th>
<th>&lt; 2 weeks</th>
<th>2 to 5 weeks</th>
<th>&gt; 52 weeks</th>
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</thead>
<tbody>
<tr>
<td>DEPRESSION</td>
<td>10.0%</td>
<td>19.0%</td>
<td>&gt; 52 weeks</td>
</tr>
<tr>
<td>OBESITY RATE</td>
<td>22.8%</td>
<td>32.7%</td>
<td>&gt; 52 weeks</td>
</tr>
<tr>
<td>HIGH BLOOD PRESSURE</td>
<td>13.2%</td>
<td>23.6%</td>
<td>&gt; 27 weeks</td>
</tr>
<tr>
<td>HIGH CHOLESTROL</td>
<td>7.9%</td>
<td>15.0%</td>
<td>&gt; 27 weeks</td>
</tr>
</tbody>
</table>

BERCHAM KAMBER THE DAILY ILLINI
SOURCE U.S. DEPARTMENT OF AGRICULTURE
Food First

Petaluma Bounty

Redwood Empire Food Bank
Employment and Skills

Sonoma County Job Link

Petaluma Adult School
Lessons Learned

• Screening for and Addressing SDOH are BOTH important, but don’t get stuck waiting in a loop of inaction.
• 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.
• Think carefully about closed loop systems.
Recommendations for Success

• Evaluate priorities and capacity before launching.
• Start small and build confidence.
• Look for opportunities for pilots and seed funding, lots of energy and interest in this field!
• Partnerships take time. Set expectations appropriately.
• This is community building work. Get outside of your clinics!
Next Steps

- Add Community Partners to Aunt Bertha (NorCal Resources)
- Incorporate Early Childhood Interventions & Partners
- Expand Criteria for PRAPARE screening to all BH visits
- Launch automated outreach outside of visits for positive responses.
- Establish Internal Community Partnership Reference Directory
Team Activity

Screening

- Which Patients?
- When?
- Where?
- Who Administers?
- Which Tool?
- How Often?

Partnership

- What domain?
- Which model?
- Who connects?
- Closed Loop?
- Communication & Feedback?

What challenges do you anticipate?
Who are your champions?
Next steps for a small test/pilot?