Petaluma Health Center

ASSESSING & ADDRESSING SOCIAL NEEDS: LESSONS LEARNED IN EARLY IMPLEMENTATION

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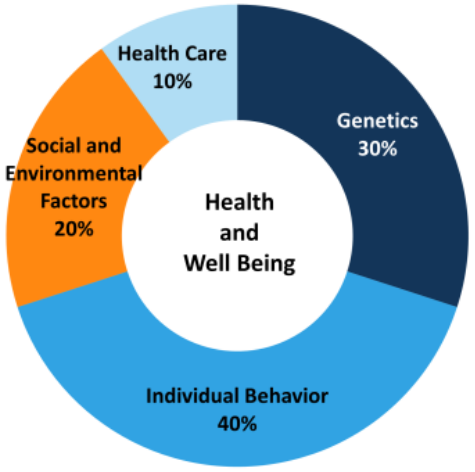
- Social determinants of health are *"the structural determinants and conditions in which people are born, grow, live, work and age."*
- There is growing recognition that a broad range of social, economic, and environmental factors shape individuals' opportunities and barriers to engage in healthy behaviors.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

Figure 1

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.

THE HENRY J. KAISER FAMILY FOUNDATION

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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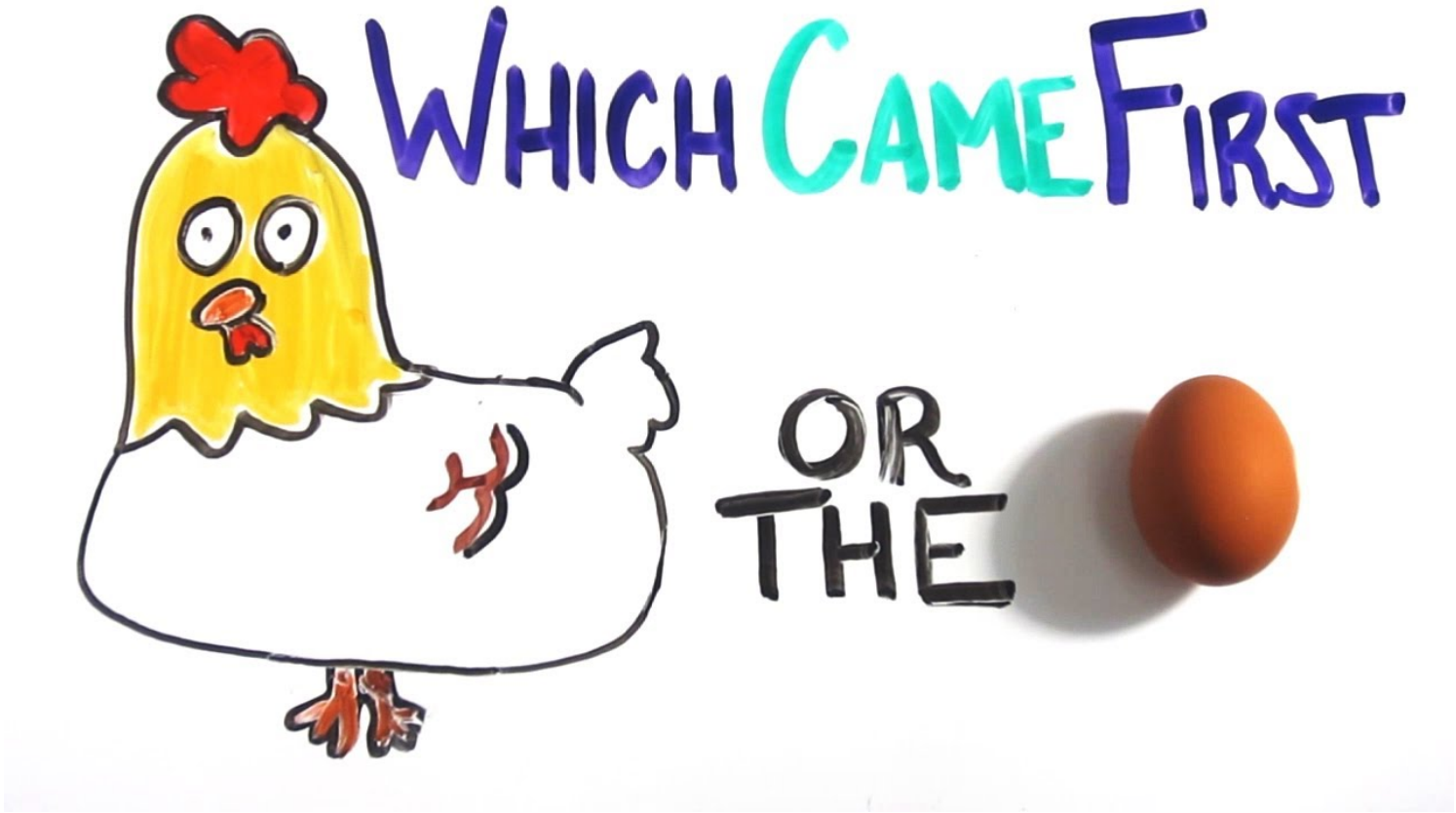

Addressing SDOH in 21st Century

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Physical Binder → Virtual Binder

- Purple Binder = *an online community resource directory and closed loop referral system.*

Successes & Challenges

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- 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

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

Aunt Bertha

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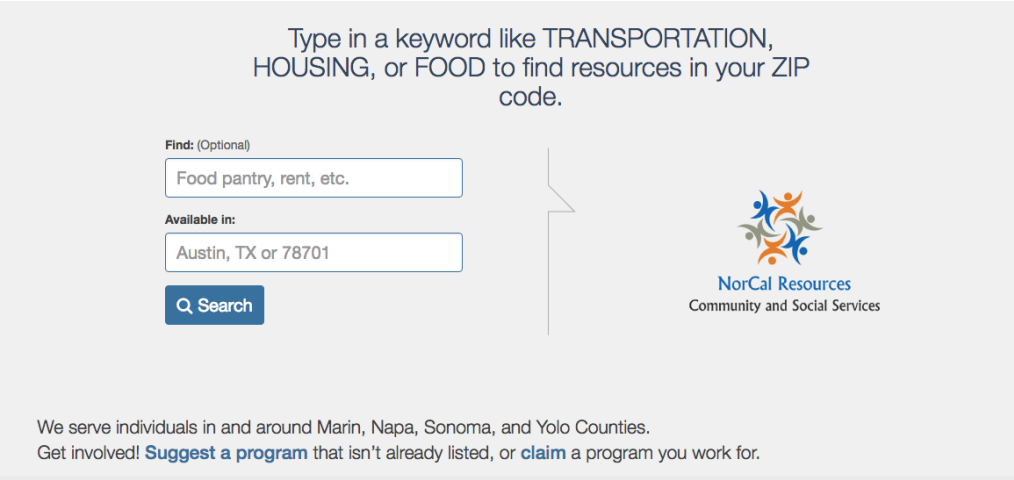

Single Sign-On
Public Facing Website
Closed Loop Referral Possible

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

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WHAT IS PRAPARE?

Protocol for **R**esponding to & **A**ssessing **P**atients' **A**ssets, **R**isks & **E**xperiences:

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

Core	
UDS SDH Domains	Non-UDS SDH Domains
1. Race	9. Education
2. Ethnicity	10. Employment
3. Veteran Status	11. Material Security
4. Farmworker Status	12. Social Integration
5. English Proficiency	13. Stress
6. Income	
7. Insurance	
8. Neighborhood	
9. Housing	

Optional	
Non-UDS SDH Domains	
1. Incarceration History	5. Safety
2. Transportation	6. Domestic Violence
3. Refugee Status	
4. Country of Origin	

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

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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 initially, then decreased to 2 or above
- Diagnosis of Diabetes or Depression

Screening Rates

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PRAPARE - Social Determinants of Health

COMPLIANCE

22%

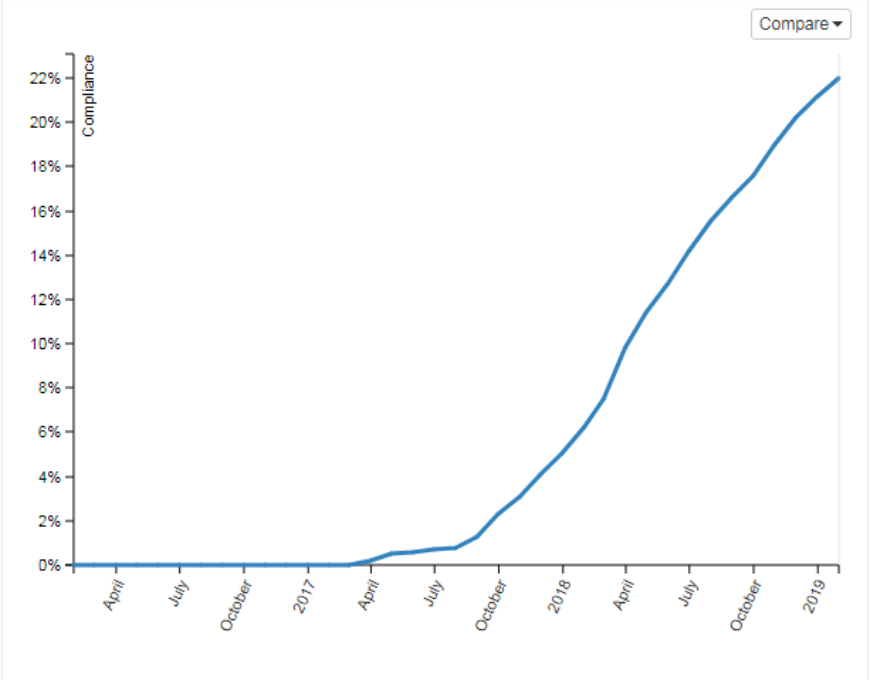
4,606
20,902

0 exclusions

TARGET

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

Compliance trend



Compliance b

Petaluma Hea

Rohnert Park Hea

Using Data to Inform Partnerships

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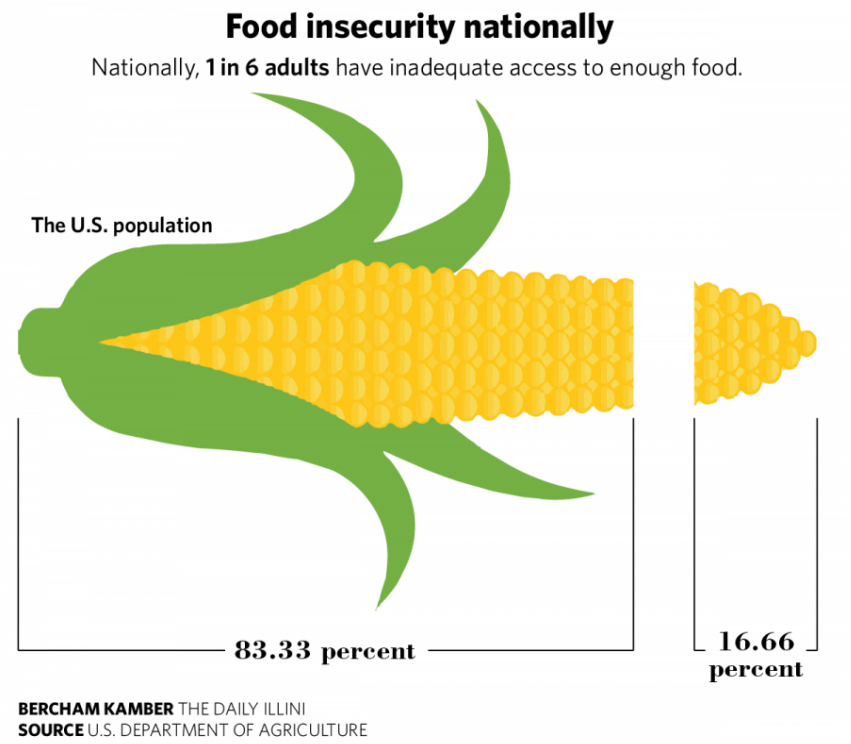

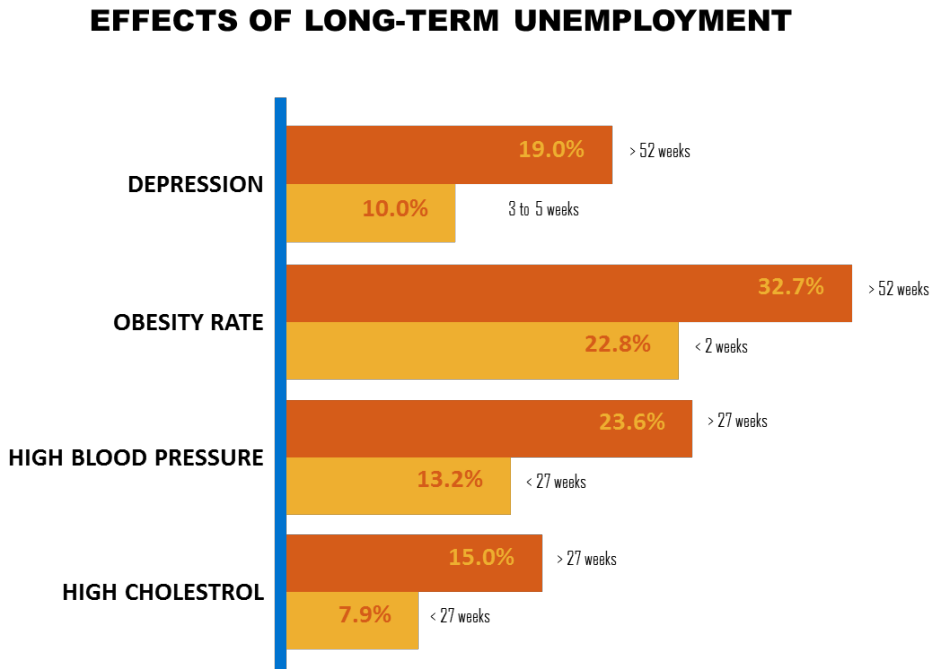

Food First

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Petaluma Bounty

Redwood Empire Food Bank

Employment and Skills

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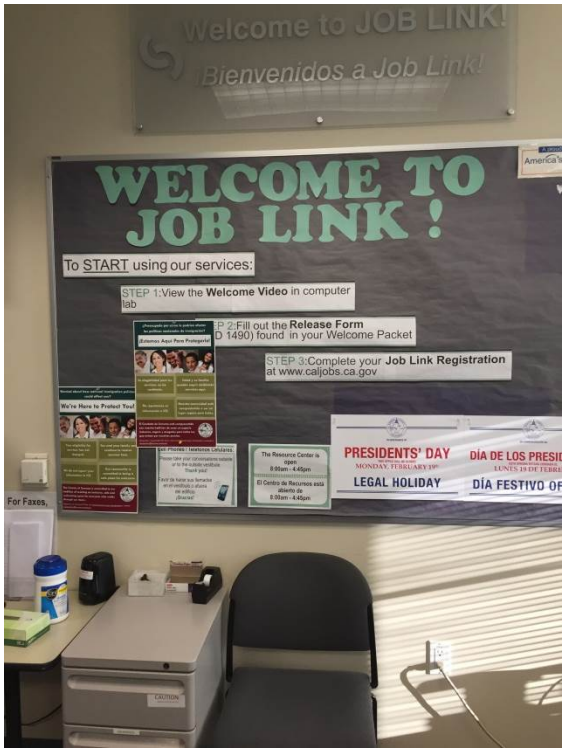
Sonoma County Job Link

Petaluma Adult School



Lessons Learned

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- 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

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- 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

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- 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

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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?