DRAFT

**PRIMARY CARE MODERNIZATION**

# Community Integration to Address Social Determinants

## CORE CAPABILITY

Identify social determinants of health and other barriers that may affect patient's healthcare outcomes and address those barriers by connecting patients to community resources.

## HOW CARE WILL IMPROVE

### CONSUMERS CAN...

- Talk to your care team about life circumstances that make it hard to get preventive care or to manage a chronic illness
- Get help finding solutions from a community health worker or care coordinator
- Get connected to community organizations that can help with housing, access to healthy food, financial support, legal services, transportation, heat for your home and other needs.

### PRIMARY CARE TEAMS CAN...

- Better understand the social determinants of health that make it hard for your patients to participate in preventive care or manage their chronic conditions.
- Incorporate social determinants of health into the care plan such as connections to food, housing, clothing and fitness programs
- Improve the quality of care by addressing common problems that may contribute to poor outcomes
    - Reduce burden on primary care team members by providing support in addressing problems that affect patient engagement

## PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Eva is a single mother of two. She does not make enough money to buy enough food for her family and she struggles to pay other bills. She also prefers speaking and reading Spanish to English. Eva goes to her primary care provider's office for a regular checkup.

While waiting to see the doctor, Eva answers some questions about her housing, food and other health factors, called a social determinants of health (SDOH) screening tool. A community health worker trained in SDOH assessments and community linkages reviews her SDOH risk and enters it into her electronic health medical record.

After Eva meets with her doctor, the community health worker meets with her to talk about her needs. She connects her with a local food pantry. They also talk about her diabetes and her struggles to eat healthy and measure her glucose levels daily.

The community health worker refers her to a program at the local community center that holds diabetes self-management courses in Spanish. The community health worker calls Eva the following week to confirm she was able to enroll in the diabetes self-management course.

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# HOW

## Care Team and Network Requirements

- Implement a standardized process for screening patients for social determinants of health using a screening tool that is linguistically and culturally appropriate and that addresses food insecurity, housing instability, utility needs, financial resource strain, transportation, exposure to violence and other areas such as childcare, education, employment, health behaviors, and social isolation/engagement
- Establish protocols for documenting in the care plan the social determinant barriers and the plan to address them
- Designate a care team member (such as a Community Health Worker) with training in social determinants of health, cultural sensitivities, and community services to address the identified social determinant barriers
- Create referral relationships with those community organizations whose services are most frequently utilized
- Establish a process for accessing an up-to-date resource directory (such as 211)
- Establish referral management protocols that include determining whether individuals were successfully linked to and served by community resources
- Track outcomes including assessment of the impact of community resources on patient experience, healthcare outcomes and cost.

## Health Information Technology Requirements

- Access for all team members to electronic health record (EHR) or interoperable software that enables the capture of coded social determinants of health risk assessment results
- Analytics that enable the analysis of performance with respect to social determinants of health
- EHR configuration or software to support referral management with respect to community resources
- EHR configuration and analytics to support outcomes measurement
- Consent and confidentiality management solution

## MEASURING IMPACT

**Patient Experience**

- Improved provider satisfaction ratings with respect to medical home support such as "asked you if there were things that make it hard for you to take care of your health"

**Quality**

- Improved preventive care (e.g., cancer screening, immunizations)
- Improved chronic illness outcomes (e.g., diabetes control)
- Reduced preventable hospital admissions for ambulatory care sensitive conditions
- Reduced all-cause unplanned hospital readmissions

**Cost**

- Reduced emergency department visits and hospital admissions for ambulatory care sensitive conditions

**Access**

- Improved access to community resources to address social determinant barriers

## IMPROVING HEALTH EQUITY

Patients experience social determinant barriers to care that result in health disparities. These disparities disproportionately affect individuals who are lower income and of certain race/ethnic groups. Improving the identification of social determinant barriers and linkage to community resources that help resolve these barriers will reduce disparities. Patients that experience disparities will be better able to engage in preventive health and management of chronic conditions.

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