Patient-Centered Primary Care Home Program Update

July 2021

Meeting PCPCH Standard 3.D: Health-Related Social Needs (and the Social Determinants of Health)

One of the big changes to the PCPCH Standards that went into effect in January of this year was the change to ***Standard 3.D - Comprehensive Health Assessment & Intervention*** which now focuses on patients' **Health-Related Social Needs (HRSN).** HRSN refers to the social and economic needs that individuals experience that affect their ability to maintain their health and well-being. They include things such as housing instability, housing quality, food insecurity, employment, personal safety, lack of transportation and affordable utilities, and more.

Health-Related Social Needs vs the Social Determinants of Health

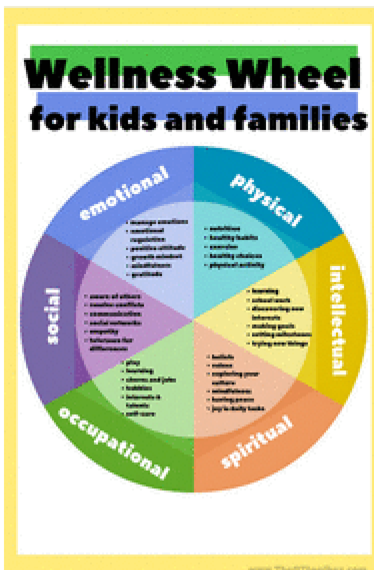
The term "Health-Related Social Needs" is sometimes used interchangeably with the Social Determinants of Health (SDOH). SDOH refers to the conditions in which people are born, grow, work, live, and age that are shaped by the distribution of money, power and resources and impacted by factors such as institutional bias, discrimination, racism, and more. In a way, disparities in HRSN can be understood as a result of the Social Determinants of Health.

Addressing the conditions in which people live and their underlying factors is often out of scope for primary care practices. However, clinics *can* take steps to address the resulting health-related social needs through understanding which ones their unique patients face, referring them to local community services, partnering with community-based organizations, or coming up with other creative interventions.

Pages 73-76 of our PCPCH Technical Assistance Guide provides an outline of how primary care practices can go about improving their patients' health through addressing HRSN. Our Resources & Technical Assistance webpage also hosts other resources for meeting Standard 3.D such as an Extra Guidance Two-Pager and a PCPCH webinar on Standard 3.D. Below are a list of HRSN screening tools (sometimes referred to as SDOH screening tools) that practices might use, although you are encouraged to use the assessment method or process that best meets your clinic's needs such as those built into your EHR.

- Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool (National Association of Community HealthCenter)
- The EveryONE Project Toolkit (American Academy of Family Physicians)
- Health-Related Social Needs Screening Tool (Accountable Health Communities)
- HealthLeads Screening Toolkit (Health Leads)

Family-centered resources to support well-child visits



In spring 2021, the OHA Transformation Center partnered with Insight for Action to conduct an environmental scan to identify resources for parents of young children (ages 3-6) to promote their children's wellness. In the spreadsheet below, Tab 2 ("Family-Centered Resources") contains a curated list of 67 free, easily digestible and family-centered resources that primary care practices such as pediatric clinics can share with patients and/or their parents during well-child visits. See tab 1 for instructions for using the built-in filters to navigate the resources.

- **Family-centered resources to support well-child visits** (full spreadsheet)
- **Webinar slides**
- **Webinar recording**
- **Contact:** Adrienne Mullock (Adrienne.P.Mullock@dhsoha.state.or.us)

ORPRN free fall Echo programs (with CME)

Enhance your expertise and join a case-based community of learners — sign up now for a fall 2021 Oregon ECHO Network (OEN) program. OEN programs connect Oregon healthcare professionals with a faculty panel of specialty care experts for sessions that include a brief didactic and an interactive case discussion. They are delivered over a videoconferencing network so you can join from anywhere in the state without leaving your community. OEN programs are always free and offer no-cost continuing medical education credits. Choose from the following offerings for fall 2021.

New OEN programs:

- Whole-Person Care for Children and Youth in Foster Care
- Gender-Affirming Care Across the Lifespan
- Veterans and Military Behavioral Health

Returning programs:

- Team-based Approaches to Diabetes Care Management
- Geriatric Care in an Age-Friendly Health System
- Integrated Behavioral Health for Pediatric Populations

Addiction medicine programs:

- Hepatitis C: Treatment and Elimination
- Hepatitis C Community of Practice
- Substance Use Disorders in Hospital Care
- Substance Use Disorders in Ambulatory Care
- Addiction Medicine Curbsides and Conversation
- Pain Management and Substance Use Disorders Dental ECHO

Programs fill quickly! Sign up today. Visit oregonechonetwork.org for more information and to register.

New diabetes metrics toolkit available

A new toolkit is available to help primary care and dental clinic settings apply quality improvement frameworks and tools for measurable change in diabetes, HBA1C poor control and oral health evaluation for adults with diabetes. This toolkit includes many real-life example improvement projects, templates and inspiration to conceptualize, design and implement your own quality improvement projects.

Diabetes metric toolkit
Contact: Sarah Wetherson (Sarah.E.Wetherson@dhsoha.state.or.us)

Questions?

We are here to help! Contact us at PCPCH@dhsoha.state.or.us.

About the Patient-Centered Primary Care Home Program

Patient-Centered Primary Care Homes (PCPCH) are health care clinics that have been recognized by the Oregon Health Authority (OHA) for their commitment to providing high quality, patient-centered care. The PCPCH Program administers the application, recognition, and verification process for practices applying to become Patient-Centered Primary Care Homes. The program is also working with stakeholders across Oregon to support adoption of the primary care home model. For more information visit www.PrimaryCareHome.oregon.gov.

The mission of the PCPCH Program is to be a trusted partner in primary care, collaborating with stakeholders to set the standard for trans formative, whole-person, and evidence-based care.