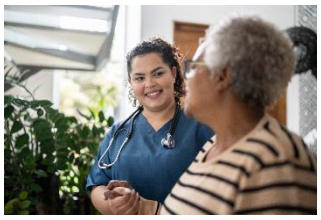
ORACLE

Advance whole-person care by tackling social risk factors



Enable care teams to support the whole person.

Key benefits

- Identify social risk factors in the patient population you serve to inform care management and population health strategies
- Incorporate social risk factors into existing care management processes and workflows
- Inform community health needs assessments and community benefit efforts by detecting vulnerabilities in your community

Health starts in your community and to improve the health of the populations you serve. It is critically important to understand the conditions in which they live. In fact, studies show that non-clinical factors can impact as much as 80% of a person's overall health.[1]

Equitable, patient-centered care

To achieve the highest level of health in your population, you need to go beyond conventional clinical care. Enable care teams to support the whole person by accounting for socioeconomic and environmental factors impacting health with Oracle Health Determinants of Health. Whether you are leading community benefit efforts or working to close the social need gaps in at-risk patients, our capabilities aim to help you provide more equitable, patient-centered care

Determinants of Health analytics

Understanding the social risk factors your patient population is experiencing can be challenging. Lack of standardized data collection, incomplete data, and limited resources and tools create barriers to adequately address the needs of populations. To make the most of your resources, we strive to create efficiencies by centralizing clinical and nonclinical data, providing a holistic view of your patient population, and allowing you to draw actionable and meaningful conclusions from your data.

Community risk insights

Strategize and implement social programs with confidence using community risk insights. Using detailed community social risk data, coupled with with EHR data and geospatial capabilities, you can identify areas of elevated social risk, such as transportation barriers, air quality, and food access, drilled down from a county to a census block group.

Population social risk insights

Our analytic insights provide population health, care management, community benefit, and clinical teams key details into social risk across the populations you serve. Whether you are conducting targeted outreach for at-risk patients, identifying social risk factors for pre-visit care management planning, implementing a community program to address food insecurity, or working through your next community health needs assessment, Oracle Health capabilities are available to help you uncover insights into your populations' social risk.

Evidence-based screening tools

Understanding and documenting patient-stated social needs is critical to provide person-centric, equitable care. Oracle Health offers multiple screening tools, allowing you to select the tool that best fits the population you serve, including PRAPARE, WellRx, Social Determinants (modeled after the Institute of Medicine's social and behavioral domains),the Accountable Health Communities Health-Related Social Needs screening tools and Social Determinants (Pediatrics).

Suggested goals and activities

Care managers are vital resources for addressing social needs. Our suggested goals and activities are automated based on screening results, enabling care managers to focus on the most impactful social risk in patients, such as food insecurity or transportation barriers, without having to leave their everyday workflow.*

Problem list automation

To create efficiencies and reduce the need for dual documentation, our problem list automation capabilities add problems to a patients' problem list based on PRAPARE responses, further highlighting the critical role social needs play in a patient's health care journey.

The Oracle difference

We are at the forefront of healthcare innovation, promoting whole-person care and advancing health equity by combining more than four decades of EHR experience, determinant of health data and geospatial mapping to zero in on social risk factors, such as food and housing insecurity. With our help, healthcare organizations can finally incorporate social risk factors into clinical care processes and community program planning.

1 Hood, C.M., K.P. Gennuso, G.R. Swain, and B.B. Catlin. 2016. County health rankings: Relationships between determinant factors and health outcomes. American Journal of PreventiveMedicine 50(2):129-135

*Must have HealtheCare to access Cerner Determinants of Health insights within care management workflow

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