Population health management | **Cerner Determinants of Health**

Advance whole-person care by tackling social risk factors

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]

To achieve the highest level of health in your population, you need to go beyond conventional clinical care. Oracle Cerner helps enable care teams to support the whole person by accounting for socioeconomic and environmental factors impacting health. Whether you are leading community benefit efforts or working to close the social need gaps in at-risk patients, Oracle Cerner capabilities aim to help you provide more equitable, patient-centered care regardless of where you are in your social determinants of health (SDOH) journey.

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 Oracle Cerner workflows
- Inform community health needs assessments and community benefit efforts by detecting vulnerabilities in your community

Cerner Determinants of Health

Help address social needs of at-risk and vulnerable populations by identifying and intervening on social risk factors through action-oriented community analytics and SDOH capabilities embedded directly in care management workflows with Cerner Determinants of Health.

[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 Preventive Medicine 50(2):129-135.

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 precious resources, we strive to create efficiencies by centralizing clinical and non-clinical data, providing a holistic view of your patient population, and allowing you to draw actionable and meaningful conclusions from your data.

Strategize and implement social programs with confidence using community risk insights. With enhanced capabilities offered by CDOH: Expanded Community Social Risk, you can take into consideration data from the United States Census Bureau, Environmental Protection Agency, Department of Housing and Urban Development, and more. Coupled 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.

Our analytic insights provide population health, care management, community benefit, and clinical teams key details into social, economic, and environmental 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 Cerner capabilities are available to help you uncover insights into your populations' social risk.

Evidence-based screening tools

While community data is key to recognizing the conditions in which your population lives, understanding and documenting patient-stated social needs is critical to provide person-centric, equitable care. Oracle Cerner 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) and the Accountable Health Communities Health-Related Social Needs screening tools.

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.*

Why Oracle Cerner

Oracle Cerner is 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 Oracle Cerner, healthcare organizations can finally incorporate social risk factors into clinical care processes and community program planning.

As policy and regulatory pressures continue to mount, coupled with growing health equity priorities, understanding and addressing social risk in the population you serve is vital. Reach out to us at populationhealth@cerner.com to discuss how Cerner Determinants of Health can support your SDOH initiatives.

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

About Oracle Cerner

We are continuously building on our foundation of intelligent solutions for the healthcare industry. Our technologies connect people and systems, and our wide range of services support the clinical, financial and operational needs of organizations of every size.

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