

## Introduction

- The UMass Office of Clinical Integration provides care management services to patients with Masshealth PCC.
- Care Managers and Care Coordinators must understand the impact of social determinants of health on patients, and find resources and services that can address patients' unique needs.
- The Hotspotting program pairs medical students with Care Managers to develop skills in recognizing and addressing barriers to maintaining health.

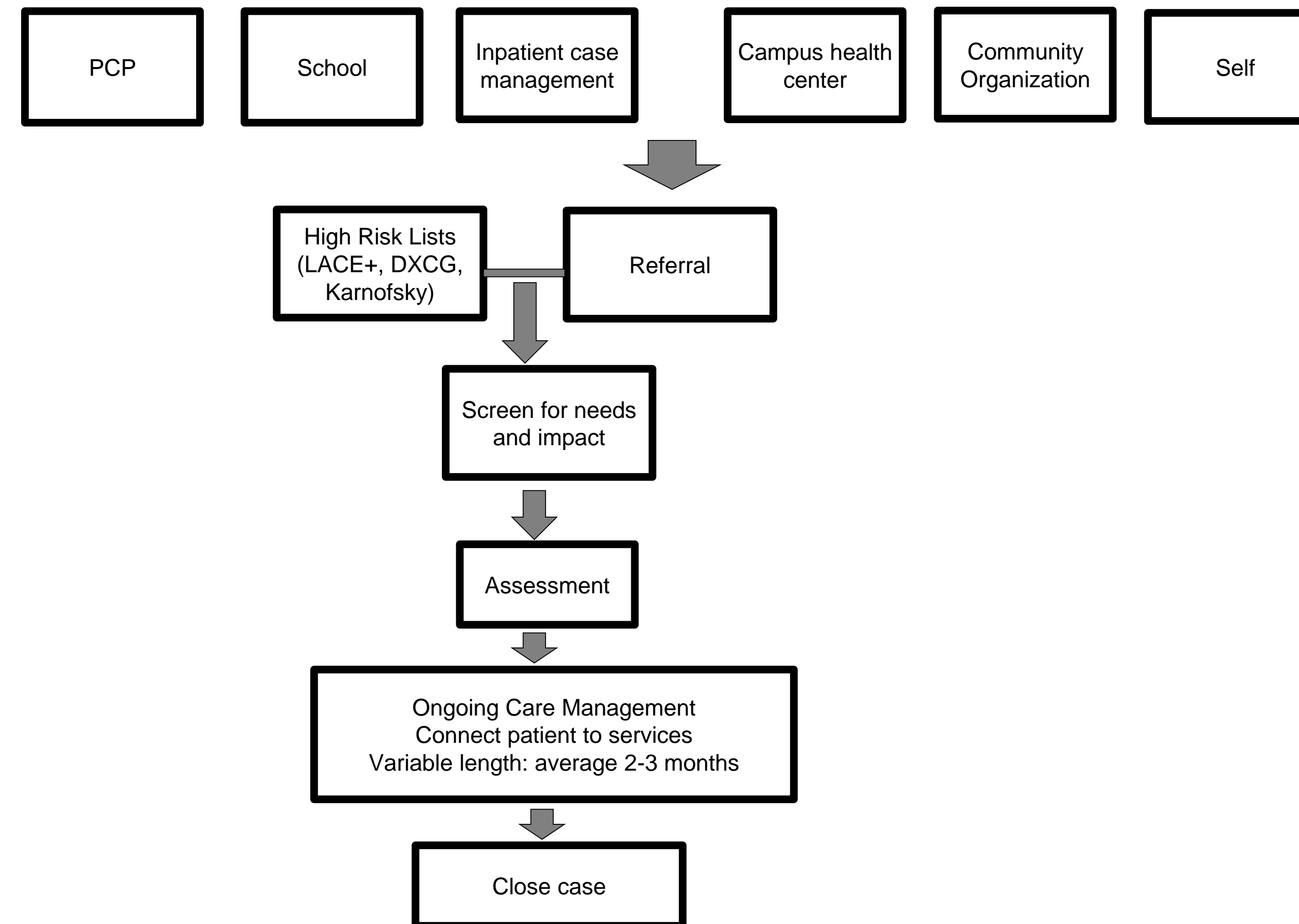
## Goals

- Connect patients to services within the community and healthcare system to help them improve their overall health
- Help patients adhere to their preventative medicine appointments
- Use preventative medicine to reduce emergency room visits
- Reduce costs through preventative medicine
- Allow medical students to work directly with patients who are often marginalized
- Examine the social determinants of health and how they affect patient care

## Target Population

- Especially important when engagement between a patient and the healthcare system is likely to fail due to:
  - Transitions of care
  - Barriers to access
  - Cultural disconnect
  - Poor social skills
  - Lack of medical understanding
- Patient eligibility:
  - Masshealth PCC plan
  - Primary care provider from an eligible site

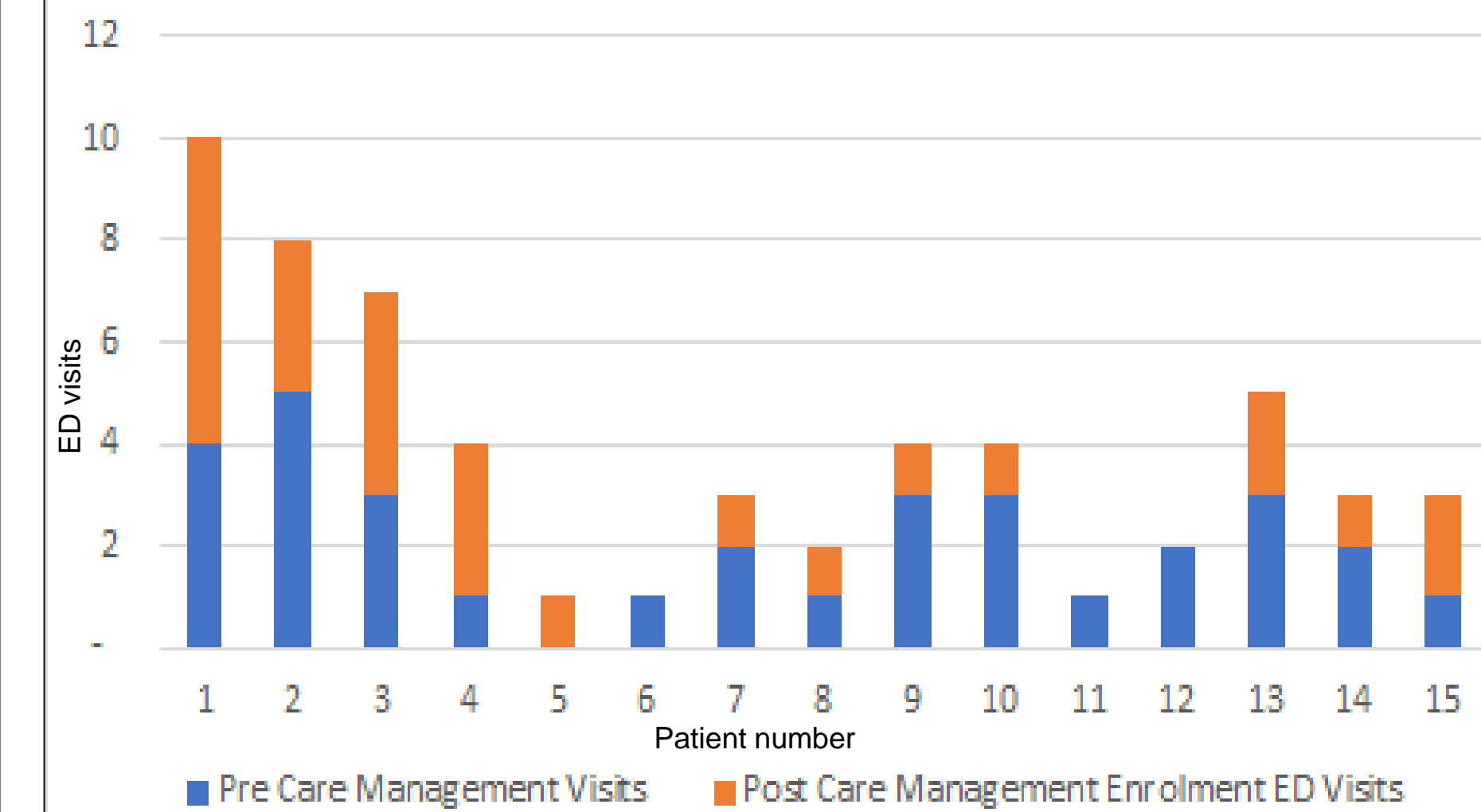
## Care Management Model:



Social Determinant	Potential Services
Housing	Section 8, CMHA, shelters, CLA
Finances	SSI, SSDI, DTA, unemployment
Transportation	PT1, bus pass, cab
Nutrition	SNAP, Community Servings, food pantries, churches, shelters, nutritionist, education
Mental Health	DMH, therapist, psychiatrist, counseling/psychiatric agencies (New Beginnings, Arbour, etc)
Intellectual Disabilities	IEP/504, in-home services, neuropsychological evaluations, CLA
Physical Disabilities	Medical Equipment, in-home services (nursing PCA, respite, etc), DPH, CLA

This table shows various Social Determinants of Health in patients along with some potential services that Hotspotters, Care Managers, and Care Coordinators may connect the patient to in order to address issues within these categories.

## Emergency Room Visits



The figure shows ED visits 6 months before and after care management. 19% decrease in ED visits was observed, with most patients using the ED less after care management.

## Future Directions

- Educate fellow medical students on the impact of Social Determinants of Health as seen through patients in the Care Management Program
- Create an **Optional Enrichment Elective (OEE)** for Hotspotting
  - Train a small group of medical students as Hotspotters for one or more years, with each student given a dedicated case to manage.
  - Lectures from various faculty members and/or Care Managers on topics related to Social Determinants of Health and Care Management
- Establish opportunities for **patient visits during the Determinants of Health (DoH) course**. Patients whose stories are examples of themes from the course would be selected to present. We hope to have several patients along with the Care Manager share their stories during lectures.

## Acknowledgements

This work was made possible by the support provided by:

- UMMHC Office of Clinical Integration: William Behan RN CCM, Amy Cundall RN CCM, Linda Potvin RN CCM, Jenepher Henkins MSW LCSW
- Department of Family Medicine and Community Health: Suzanne Cashman ScD MS, Heather-Lyn Haley PhD