PRAPARE Social Determinants of Health in the EHR

OCHIN Epic Tools for Data Collection, Screening, and Referral

WE ARE OCHIN

What are Social Determinants of Health (SDH)?

Adapted from www.HealthyPeople.gov

- Nonmedical factors influencing health (Braveman et al 2011)
- Health starts long before illness (Robert Wood Johnson Foundation)
- Health starts in our homes, schools, workplaces, neighborhoods, and communities (Healthy People 2020)
- The conditions in which people are born, grow, live, work and age, and which are shaped by the distribution of money, power and resources at global, national and local levels (WHO)

Examples of Social Determinants of Health (SDH)

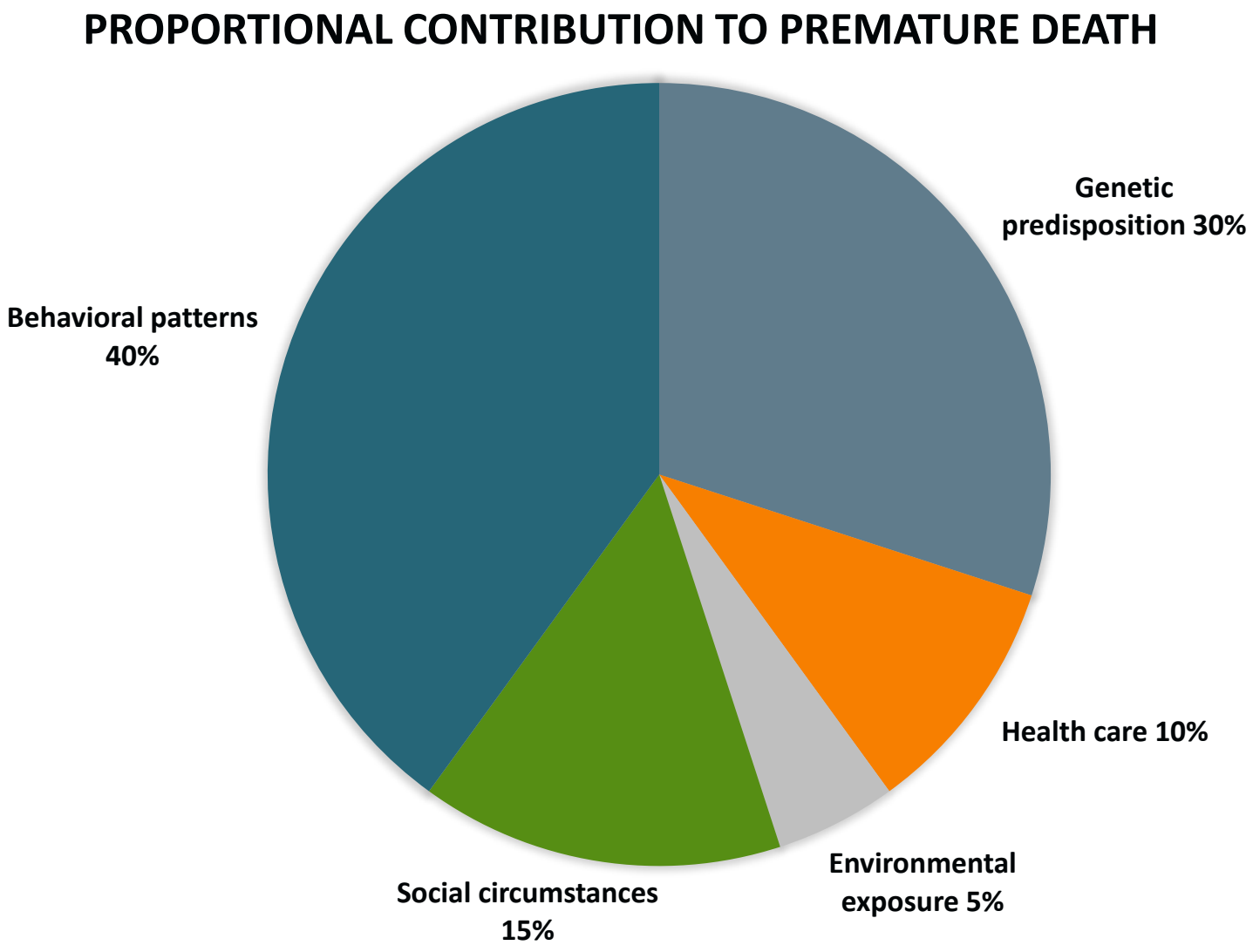
Community-level factors

- *% of community living in poverty*
- *% high school or college graduates*
- *Built environment*
- *Walkability of neighborhood*
- *Crime*

Individual-level factors

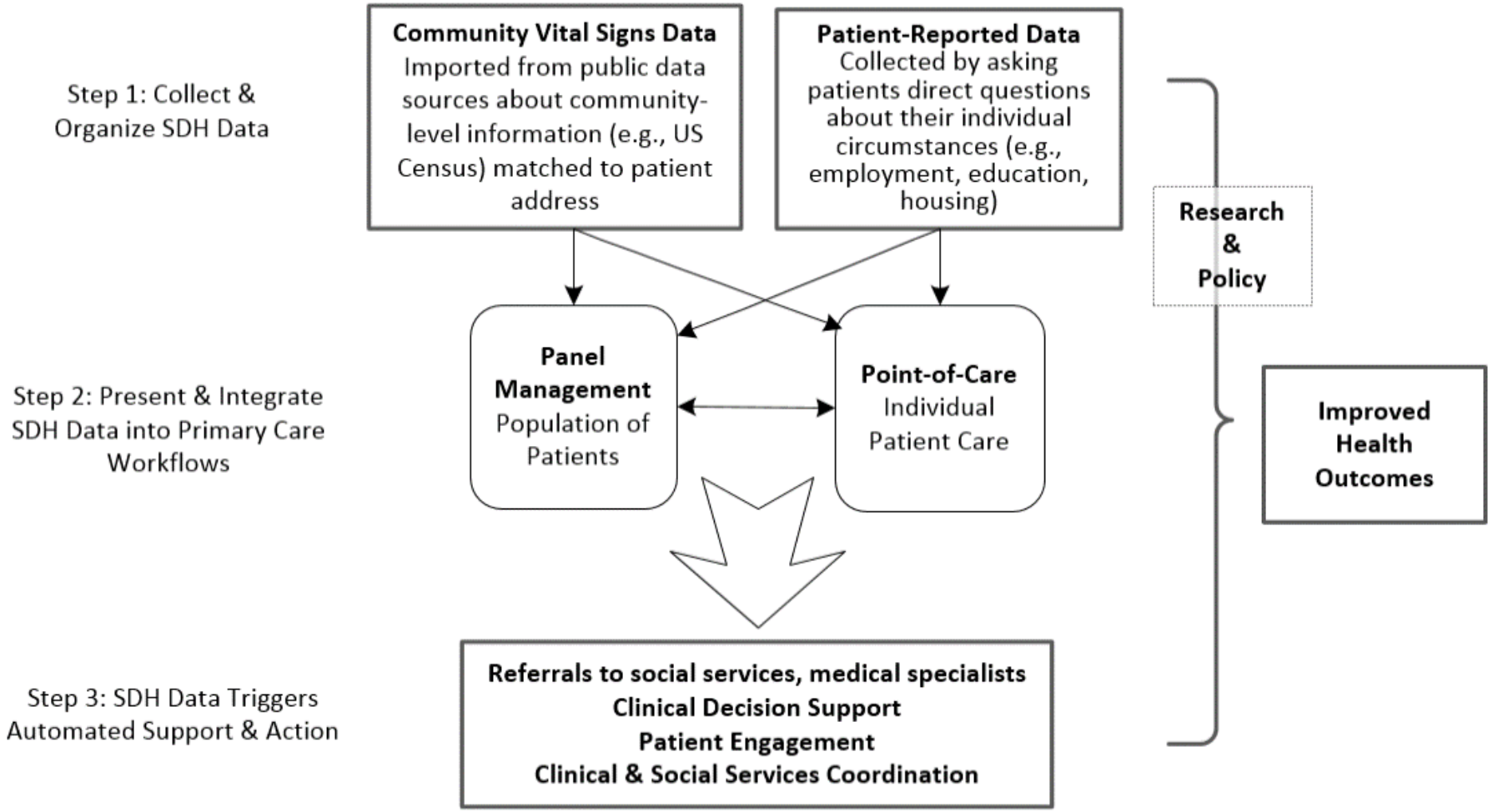
- *Household income*
- *Education*
- *Housing status*
- *Food security*
- *Social connection / isolation*

Why are SDH important in Primary Care?



McGinnis et al. The case for more active policy attention to health promotion. *Health Affairs*. 2002;21(2):78-93.

Conceptual Model for SDH in Primary Care



See: DeVoe JE, Bazemore AW, Cottrell EK, Likumahuwa-Ackman S, Grandmont J, Spach N, Gold R (2016). Perspectives in Primary Care: A Conceptual Framework and Path to Integrating Social Determinants of Health Into Primary Care Practice. *Annals of Family Medicine*, *14*(2).

How Can Community Health Centers Use SDH?

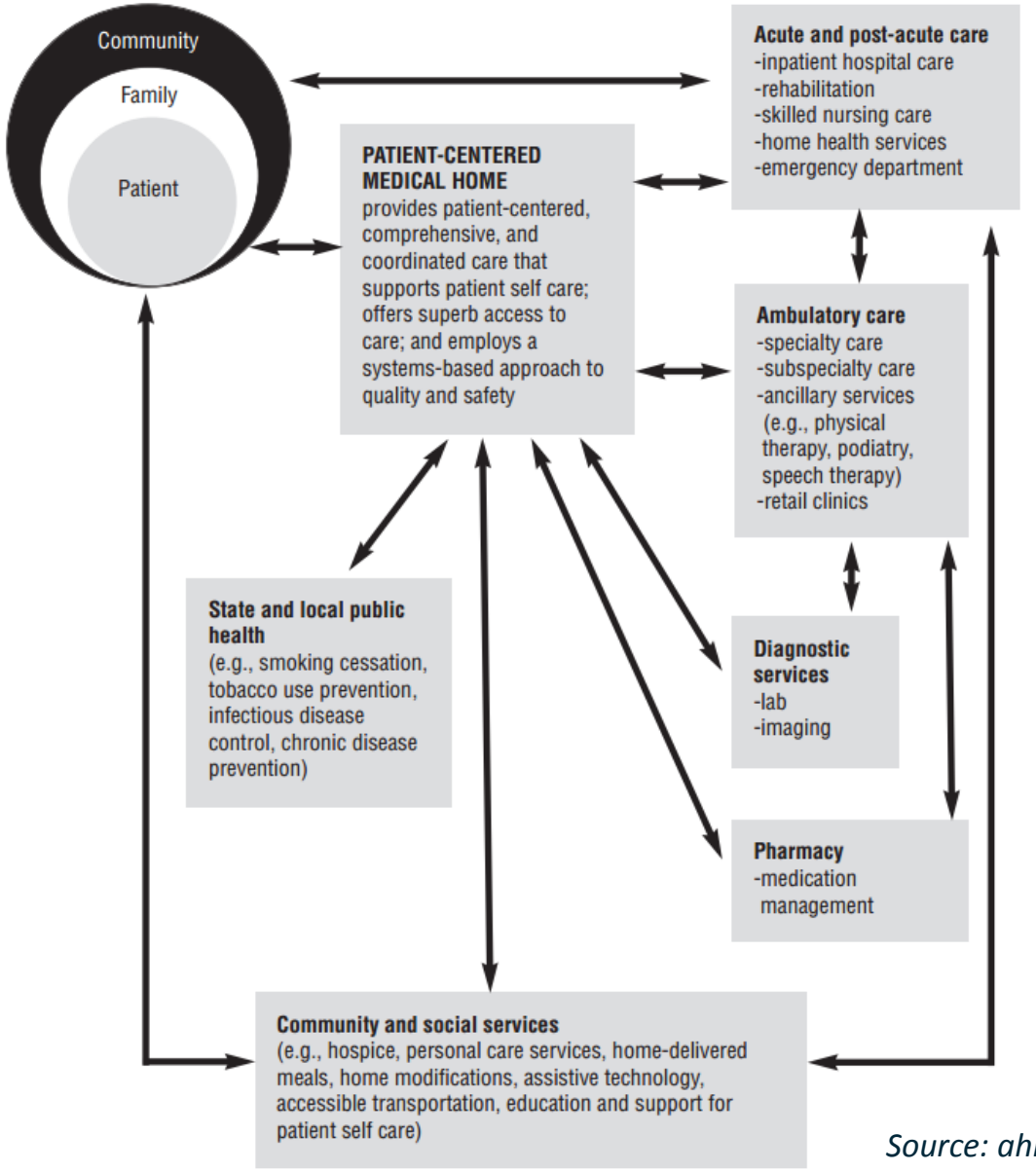
How can SDH be used in Community Health Centers?

- Connect individual patients to community resources
  - Coordinate care beyond medical setting
- Data to provide direction for advocacy and investment
  - Demonstrate areas of inequity and need in community
- Segmentation of patient populations
  - Direct resources to high-leverage activities in patient subpopulations
- Risk stratification
  - Compare risk and complexity across patient panels or populations

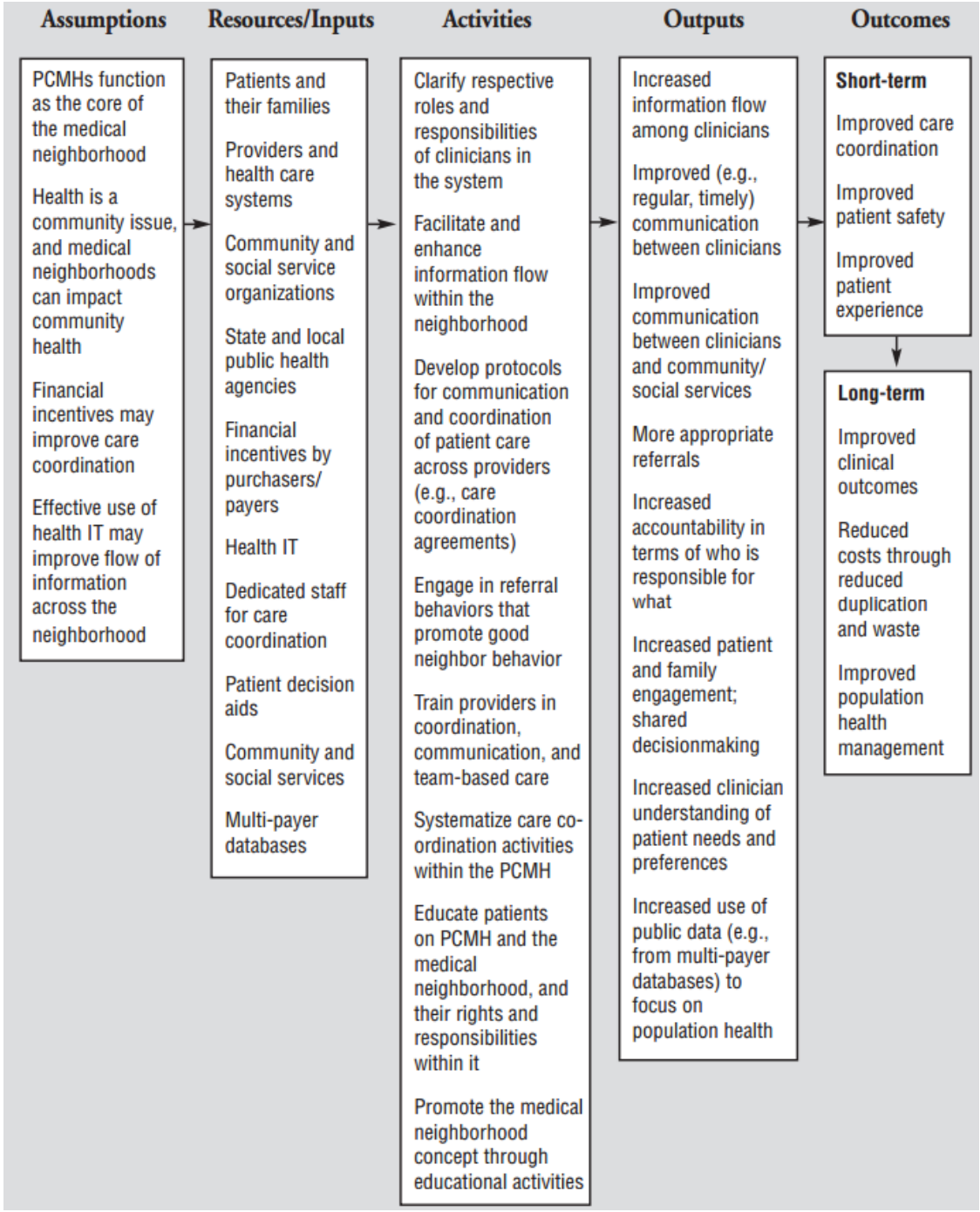
Connections to Community Resources

- Referrals to community resources based on social or other needs identified by screening for SDH
- Patient-Centered Medical Home as hub of medical and extra-medical care coordination
  - Functions as the center of a “Medical Neighborhood”
- Reflected in increasingly diverse staff roles at CHCs
  - Community health workers, case/care managers, social workers, patient advocates, etc.

The Medical Neighborhood



Source: ahrq.gov



Advocacy and Demonstrating Areas of Need

- SDH represent data to identify and encourage action to address inequality and disparities in communities and around the globe.

J Public Health Manag Pract. 2008 November ; 14(Suppl): S8–17. doi:10.1097/01.PHH.0000338382.36695.42.

Moving Upstream: How Interventions that Address the Social Determinants of Health can Improve Health and Reduce Disparities

David R. Williams, PhD, MPH[1,2], Manuela V. Costa, MPH[1], Adebola O. Odunlami, MPH[1], and Selina A. Mohammed, PhD[3]

[1]Department of Society, Human Development and Health, Harvard School of Public Health, Boston, MA

[2]Departments of African and African American Studies and Sociology, Harvard University, Cambridge, MA

[3]Nursing Program, University of Washington Bothell, Bothell, WA

Abstract

There is considerable scientific and policy interest in reducing socioeconomic and racial/ethnic disparities in healthcare and health status. Currently, much of the policy focus around reducing health disparities has been geared towards improving access, coverage, quality and the intensity of healthcare. However, health is more a function of lifestyles linked to living and working

World Health Organization

Media centre | Publications | Countries | Programmes | Governance | About WHO | Search

Social determinants of health

Taking action to improve health equity

© Zoltan Balogh

Portuguese fisherman in Torreira, Portugal, 2009

Governments are committed to taking action against health inequities – in collaboration with civil society, United Nations and development organizations, academia, donors and the private sector – in five priority areas (as specified by the Rio Political Declaration on Social Determinants of Health): enhancing health policies and decision-making, widening participation in policy-making and implementation, improving health care and services, strengthening international cooperation, and monitoring impact and progress. This section describes the action being taken to address SDH.

Global Plan of Action on Social Determinants of Health

WHO Secretariat has developed a Global Plan of Action on Social Determinants of Health (the Global Plan) that identifies and defines how the Secretariat will assist Member States and partners in the implementation of the Rio Political Declaration and thus improve health equity. WHO is supporting implementation in five Action

The Global Commission on SDH

About the commission on Social Determinants of Health

Segmenting Patient Populations – High Leverage Activities

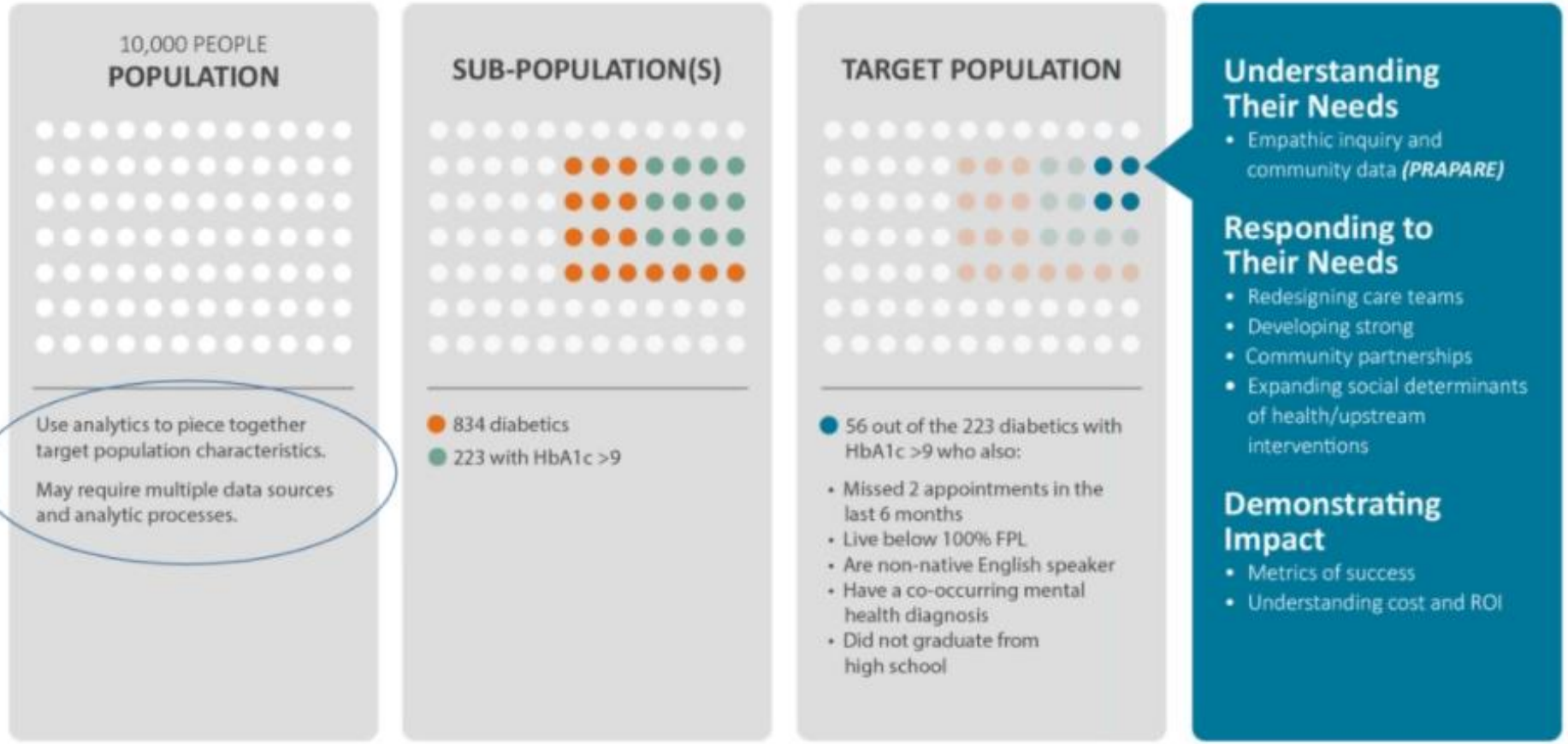


Illustration Courtesy of Oregon Primary Care Association

How the OCHIN SDH Tools Were Developed

National SDH Initiatives: PRAPARE, IOM Recommendations

UDS SDH Domains

- Race
- Ethnicity
- Veteran Status
- Farmworker Status
- English Proficiency
- Income
- Insurance
- Neighborhood
- Housing

Non-UDS SDH Domains

- Education
- Employment
- Material Security
- Social Integration
- Stress
- Transportation

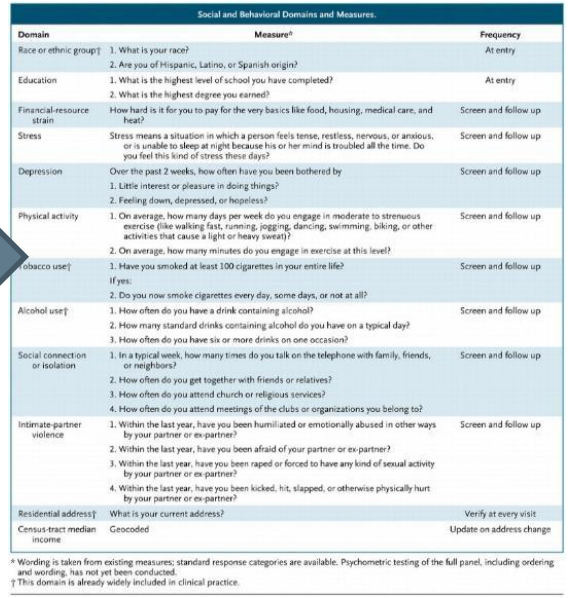
CAPTURING SOCIAL & BEHAVIORAL DOMAINS & MEASURES IN ELECTRONIC HEALTH RECORDS: PHASE 2

This document showcases the core domains and measures that constitute an efficient panel, which the committee recommends for inclusion in all electronic health records.

TABLE S-3 Core Domains and Measures

Domain	Measure
• Race/ethnicity	• U.S. Census (2 Q)
• Education	• Educational attainment (2 Q)
• Financial resource strain	• Overall financial resource strain (1 Q)
• Stress	• Elo et al. (2003) (1 Q)
• Depression	• PHQ-2 (2 Q)
• Physical activity	• Exercise Vital Sign (2 Q)
• Tobacco use and exposure	• NHIS (2 Q)
• Alcohol use	• AUDIT-C (3 Q)
• Social connections and social isolation	• NHANES III (4 Q)
• Exposure to violence: Intimate partner violence	• HARK (4 Q)
• Neighborhood and community compositional characteristics	• Residential address • Census tract-median income

NOTE: Q = question(s).



Social and Behavioral Domains and Measures.

Domain	Measure*	Frequency
Race or ethnic group†	1. What is your race?	At entry
	2. Are you of Hispanic, Latino, or Spanish origin?	
Education	1. What is the highest level of school you have completed?	At entry
	2. What is the highest degree you earned?	
Financial-resource strain	How hard is it for you to pay for the very basics like food, housing, medical care, and heat?	Screen and follow up
Stress	Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his or her mind is troubled all the time. Do you feel this kind of stress these days?	Screen and follow up
Depression	Over the past 2 weeks, how often have you been bothered by	Screen and follow up
	1. Little interest or pleasure in doing things?	
	2. Feeling down, depressed, or hopeless?	
Physical activity	1. On average, how many days per week do you engage in moderate to strenuous exercise (like walking fast, running, jogging, dancing, swimming, biking, or other activities that cause a light or heavy sweat)?	Screen and follow up
	2. On average, how many minutes do you engage in exercise at this level?	
Tobacco use†	1. Have you smoked at least 100 cigarettes in your entire life?	Screen and follow up
	If yes:	
	2. Do you now smoke cigarettes every day, some days, or not at all?	
Alcohol use†	1. How often do you have a drink containing alcohol?	Screen and follow up
	2. How many standard drinks containing alcohol do you have on a typical day?	
	3. How often do you have six or more drinks on one occasion?	
Social connection or isolation	1. In a typical week, how many times do you talk on the telephone with family, friends, or neighbors?	Screen and follow up
	2. How often do you get together with friends or relatives?	
	3. How often do you attend church or religious services?	
	4. How often do you attend meetings of the clubs or organizations you belong to?	
Intimate-partner violence	1. Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?	Screen and follow up
	2. Within the last year, have you been afraid of your partner or ex-partner?	
	3. Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?	
	4. Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?	
Residential address†	What is your current address?	Verify at every visit
Census-tract median income	Geocoded	Update on address change

* Wording is taken from existing measures; standard response categories are available. Psychometric testing of the full panel, including ordering and wording, has not yet been conducted.
† This domain is already widely included in clinical practice.

Adler NE, Stead WW. N Engl J Med 2015;372:698-701.

OCHIN Clinical Operations Review Committee

- Workgroup of OCHIN member clinical and operational leadership
  - Recommends and designs collaborative-wide Epic build
- Considered national PRAPARE toolkit questions as well as IOM recommendations
- Input from OCHIN Research team, Primary Care Associations, NACHC, and other subject matter experts
- Used clinically-validated questions and components where possible
- Prioritized clinically relevant SDH actionable in CHC setting
  - Housing, food insecurity

List of Patient-Level Social Determinants of Health in Epic

Current SDH Data Collected (PM)

- Demographics (address, age, gender, language, race, ethnicity, etc.)
- Federal poverty level
- Health Insurance status
- Homeless status

Current SDH Data Recorded (EHR)

- Alcohol use
- Tobacco use and exposure
- Depression

New SDH Section in PM/EHR Tools

- Education and learning
- Financial resource strain
- Intimate partner violence
- Physical activity
- Social connections & social isolation
- Stress
- Sexual orientation/gender identity
- Housing
- Food insecurity

Paper Version Of The Screening Tool

SDH Patient Questionnaire (Social Needs Questionnaire)

Health starts – long before illness – in our homes, schools, and jobs. The more we know about you the better health care we can provide. The following questions will help us understand more about you. Your care team will use your answers to help you improve your health. These responses will be entered into your medical record and, as with all medical information, will always be kept private and confidential.

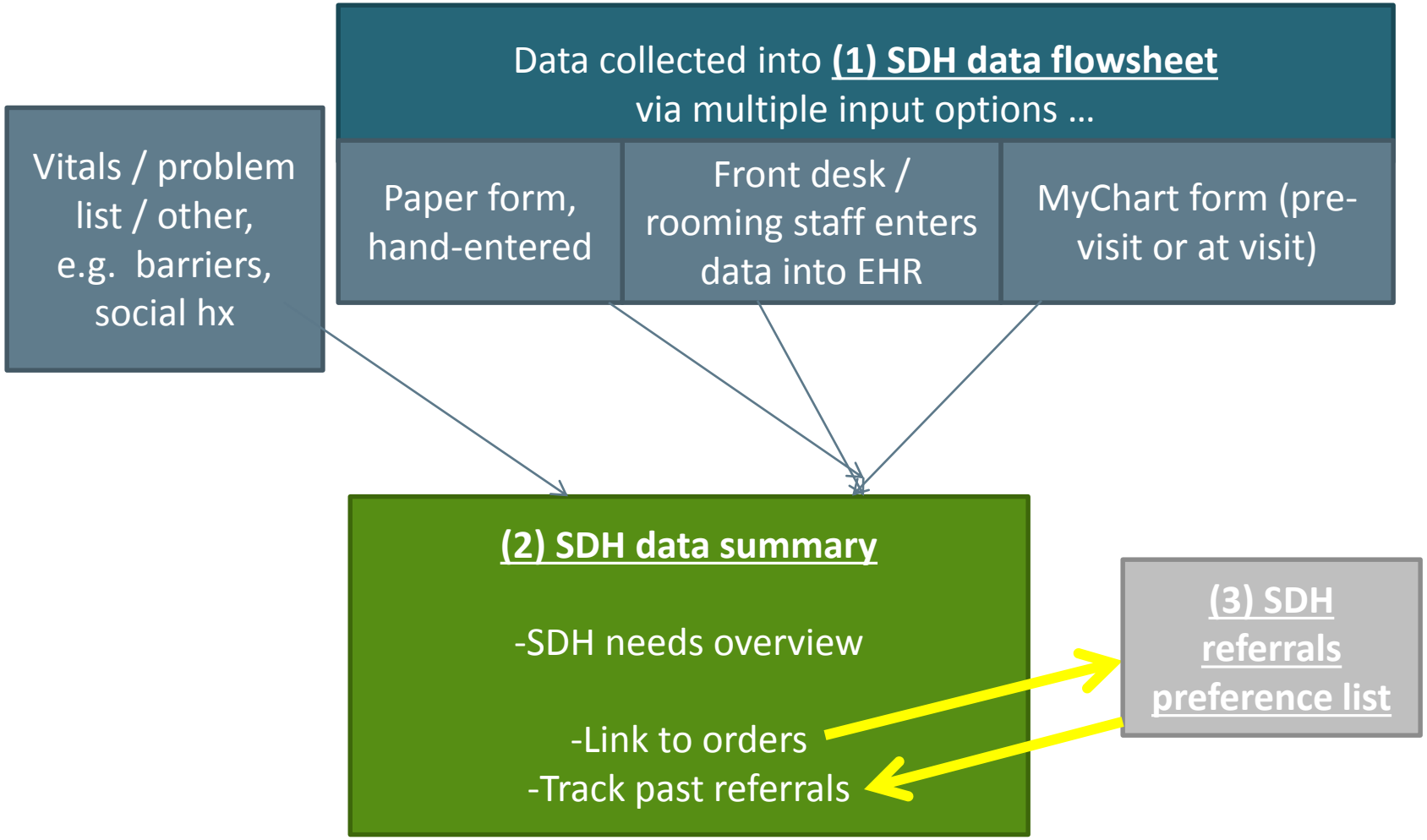
1. How do you learn best?
   ☐ Reading ☐ Listening ☐ Pictures

2. What is the highest level of school that you have finished?
   ☐ Less than a high school diploma ☐ High school diploma / GED ☐ More than high school

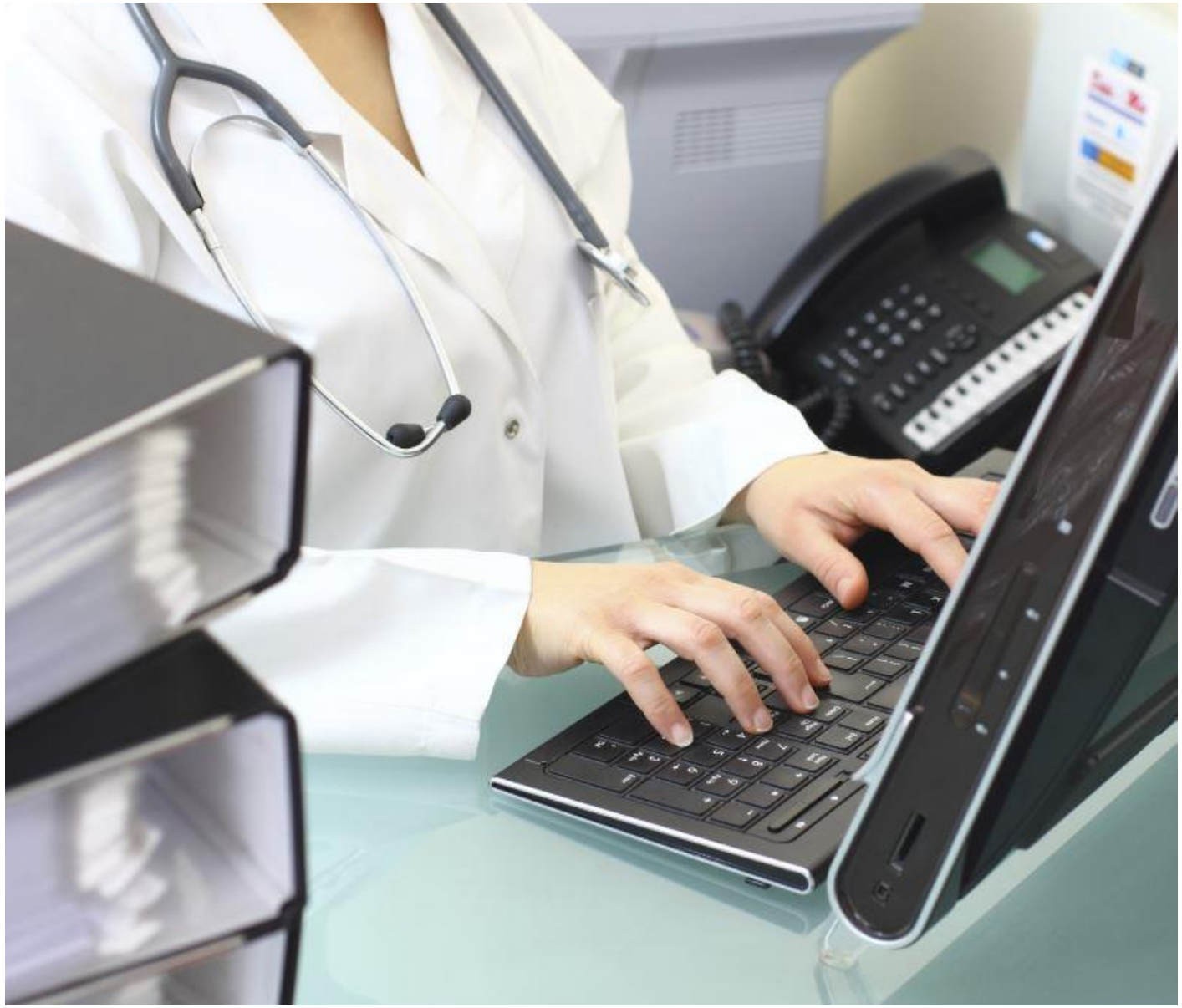
3. How hard is it for you to pay for the very basics like food, housing, heating, medical care, and medications?
   ☐ Not hard at all ☐ Somewhat hard ☐ Very hard

Full questionnaire Available in English and Spanish

Designed for Flexibility in Use and Workflow



Tools for Collecting and Acting On SDH in Epic: A System Walkthrough



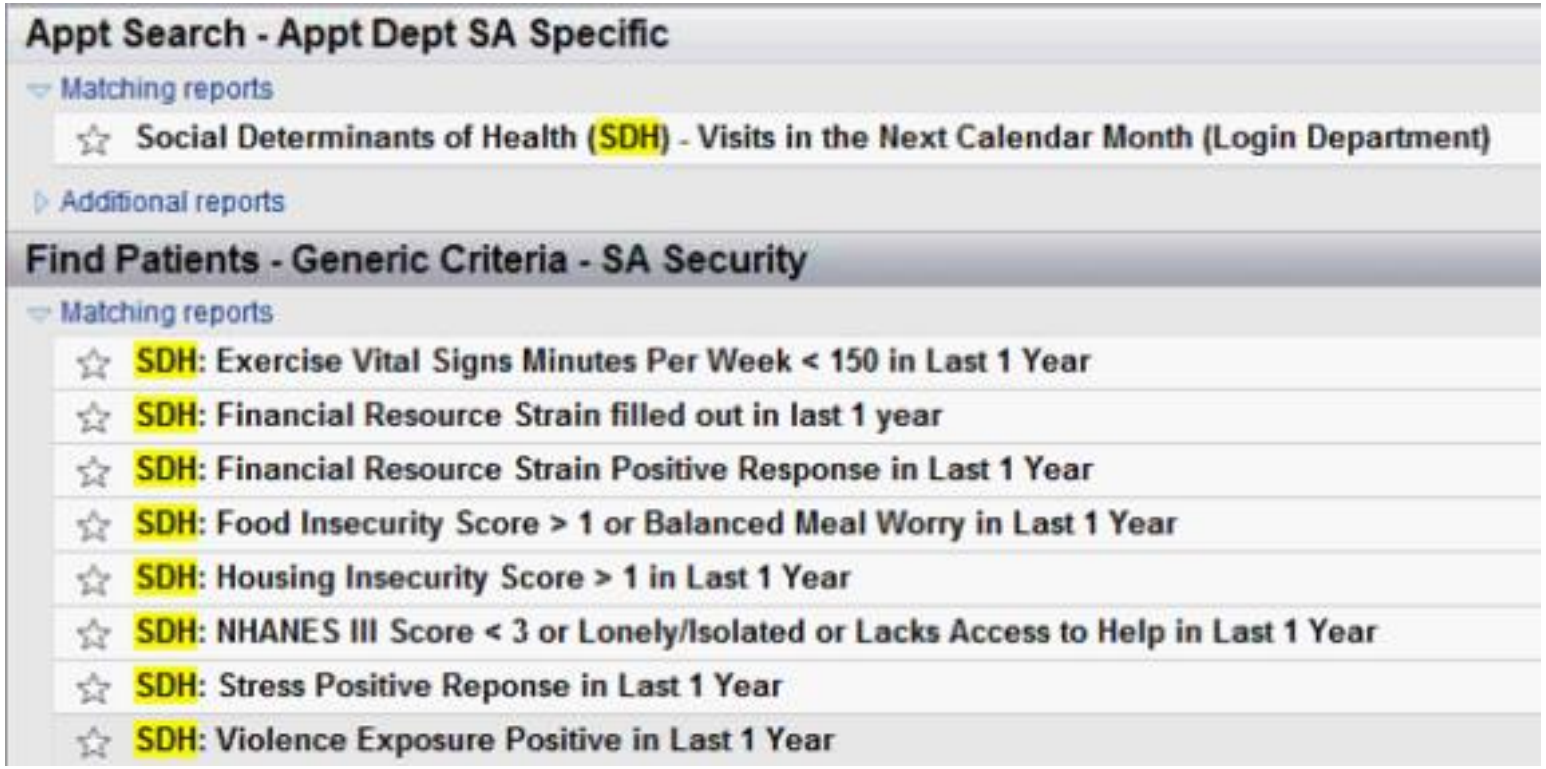
SDH And Follow-Up System Walkthrough

Two Scenario Walkthroughs:

In-clinic workflows

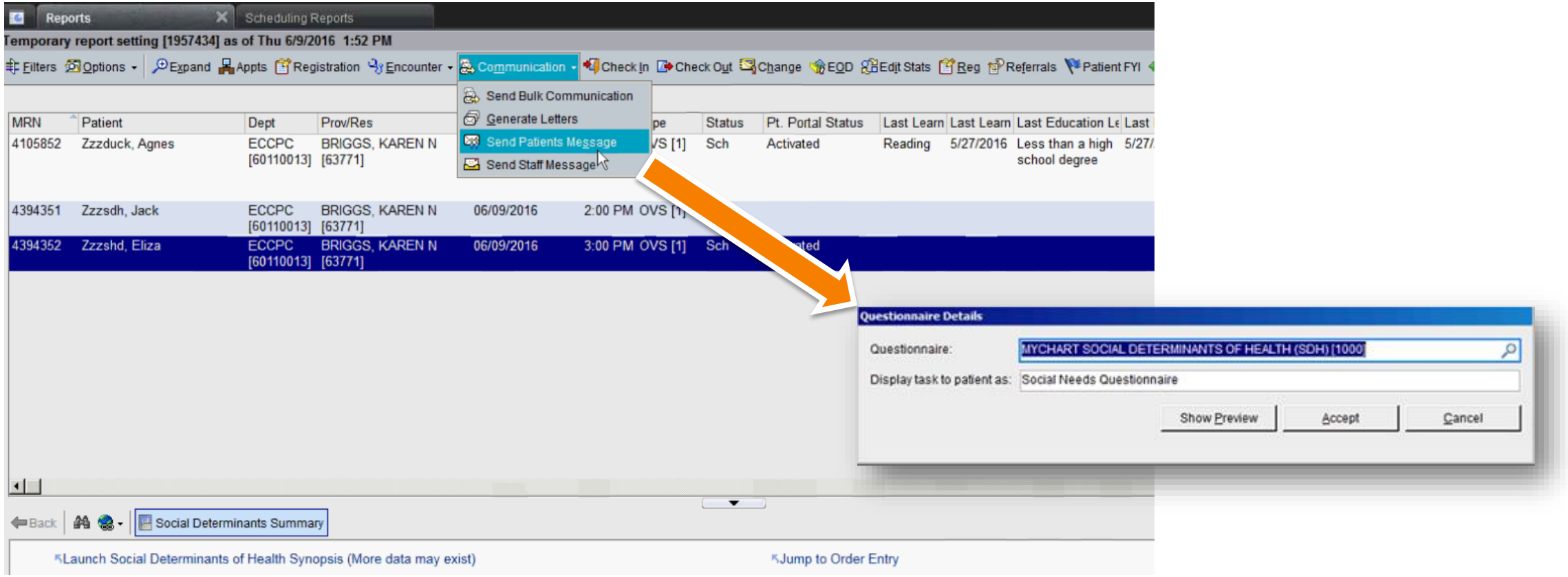
Outreach workflows

SDH Reports in Reporting workbench



Run Report and Send MyChart Portal Message

Sending request via MyChart to complete MyChart SDH Questionnaire



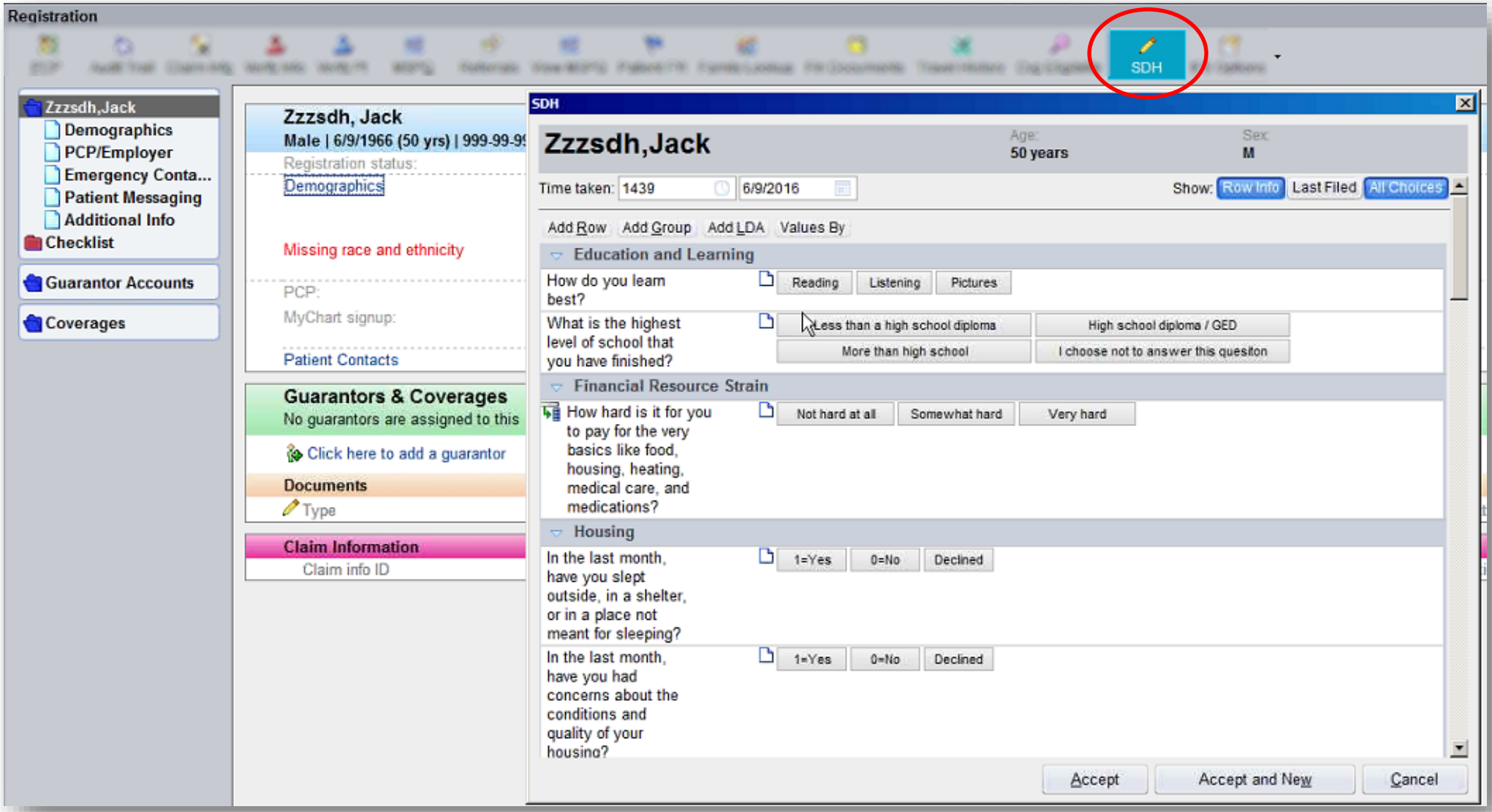
Department Appointment Report

Full Appointment List | Appointment Totals

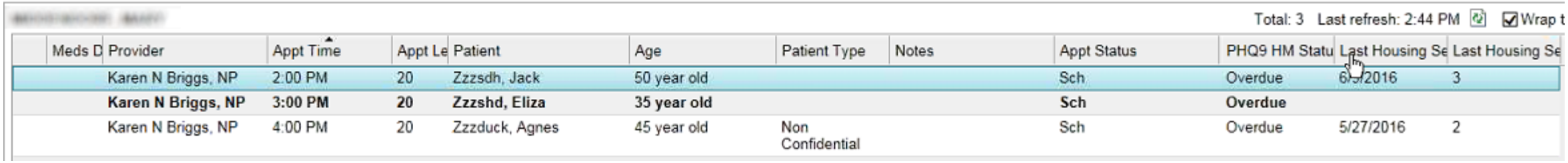
Date 6/9/2016 Department: MC EAST COUNTY PC[60110013]

Date	Time	Patient	Phone	Prov/Res	Status	Type	Appt Notes	Last Housi	Last Housi
06/09/2016	2:00 PM	Zzzsdh, Jack		BRIGGS, KAREN N [63771]	Sch	OVS [1]			
06/09/2016	3:00 PM	Zzzshd, Eliza		BRIGGS, KAREN N [63771]	Sch	OVS [1]			
06/09/2016	4:00 PM	Zzzduck, Agnes	Hm: +541-425-1234x6	BRIGGS, KAREN N [63771]	Sch	OVS [1]		5/27/2016	2

Access to the SDH Flowsheet from Registration



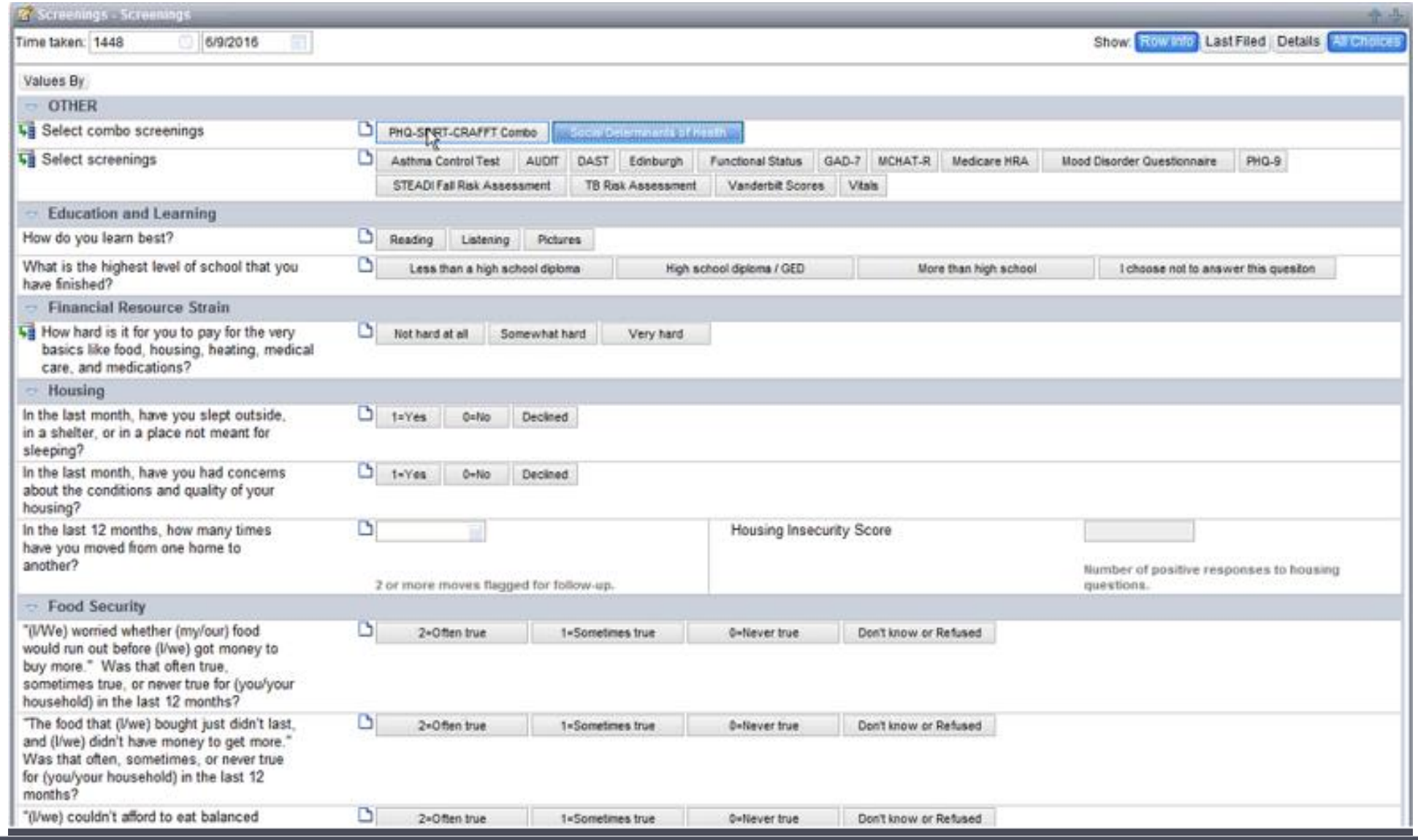
Patient Schedule



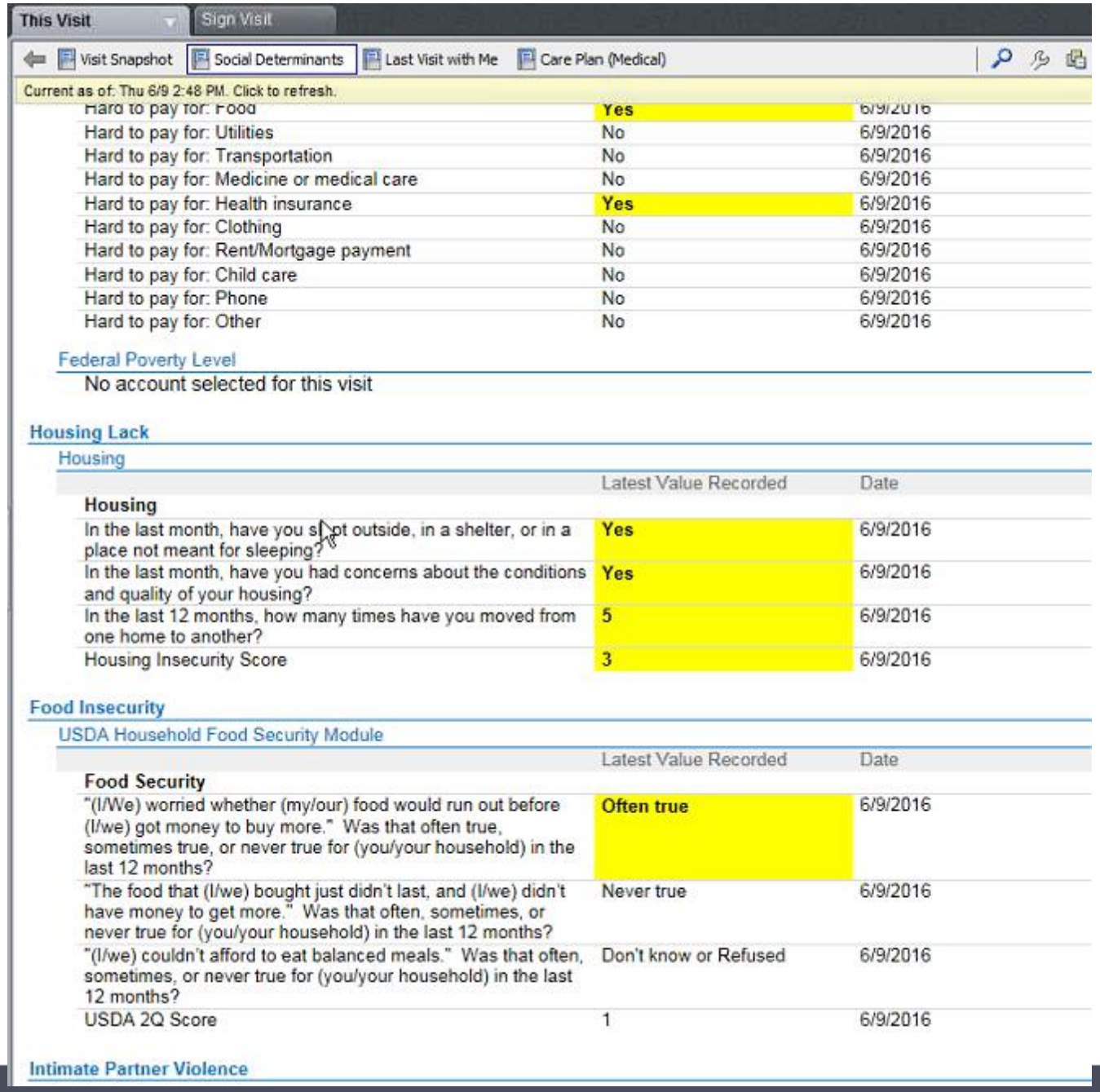
Total: 3 Last refresh: 2:44 PM Wrap t

Meds D	Provider	Appt Time	Appt Le	Patient	Age	Patient Type	Notes	Appt Status	PHQ9 HM Statu	Last Housing Se	Last Housing Se
	Karen N Briggs, NP	2:00 PM	20	Zzzsdh, Jack	50 year old			Sch	Overdue	6/3/2016	3
	Karen N Briggs, NP	**3:00 PM**	**20**	**Zzzshd, Eliza**	**35 year old**			**Sch**	**Overdue**		
	Karen N Briggs, NP	4:00 PM	20	Zzzduck, Agnes	45 year old	Non Confidential		Sch	Overdue	5/27/2016	2

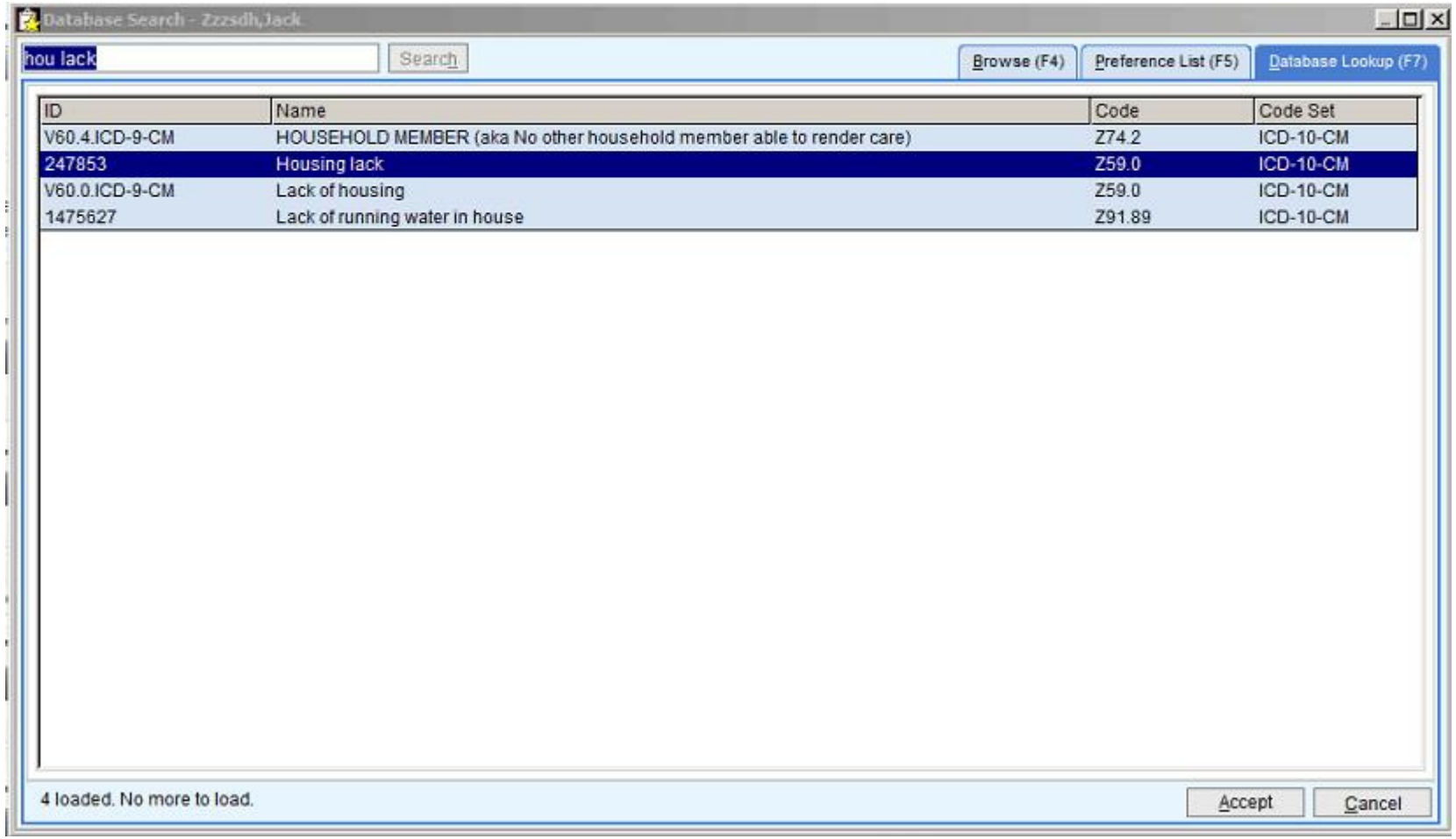
SDH Flowsheet in Patient Chart



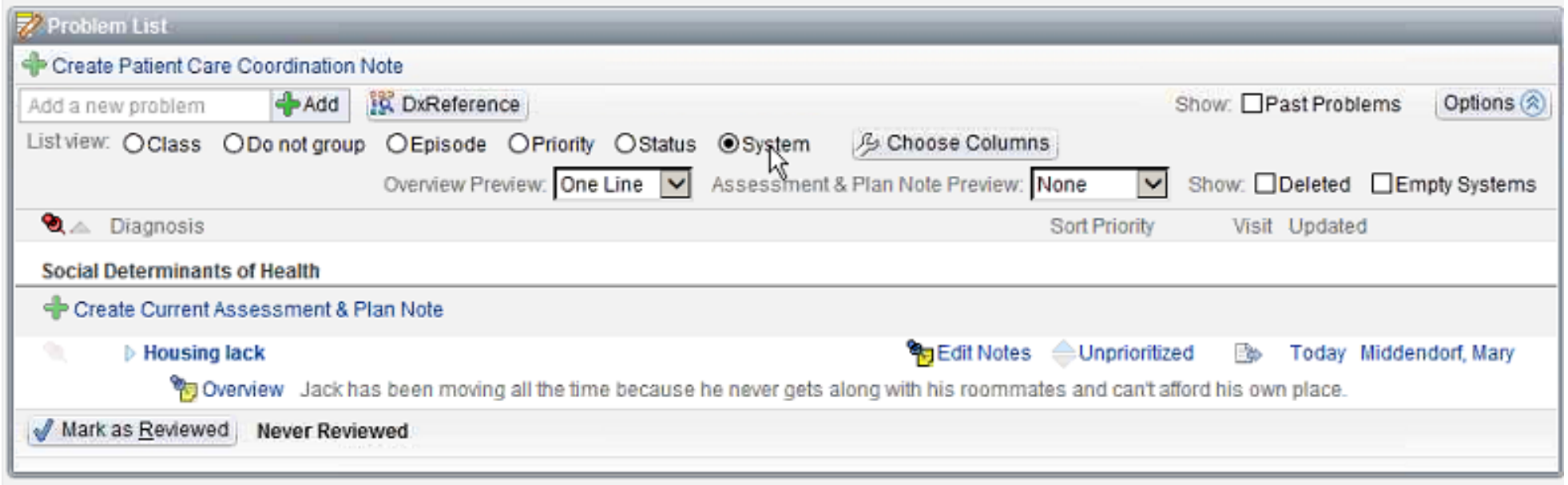
SDH Summary in Patient Chart



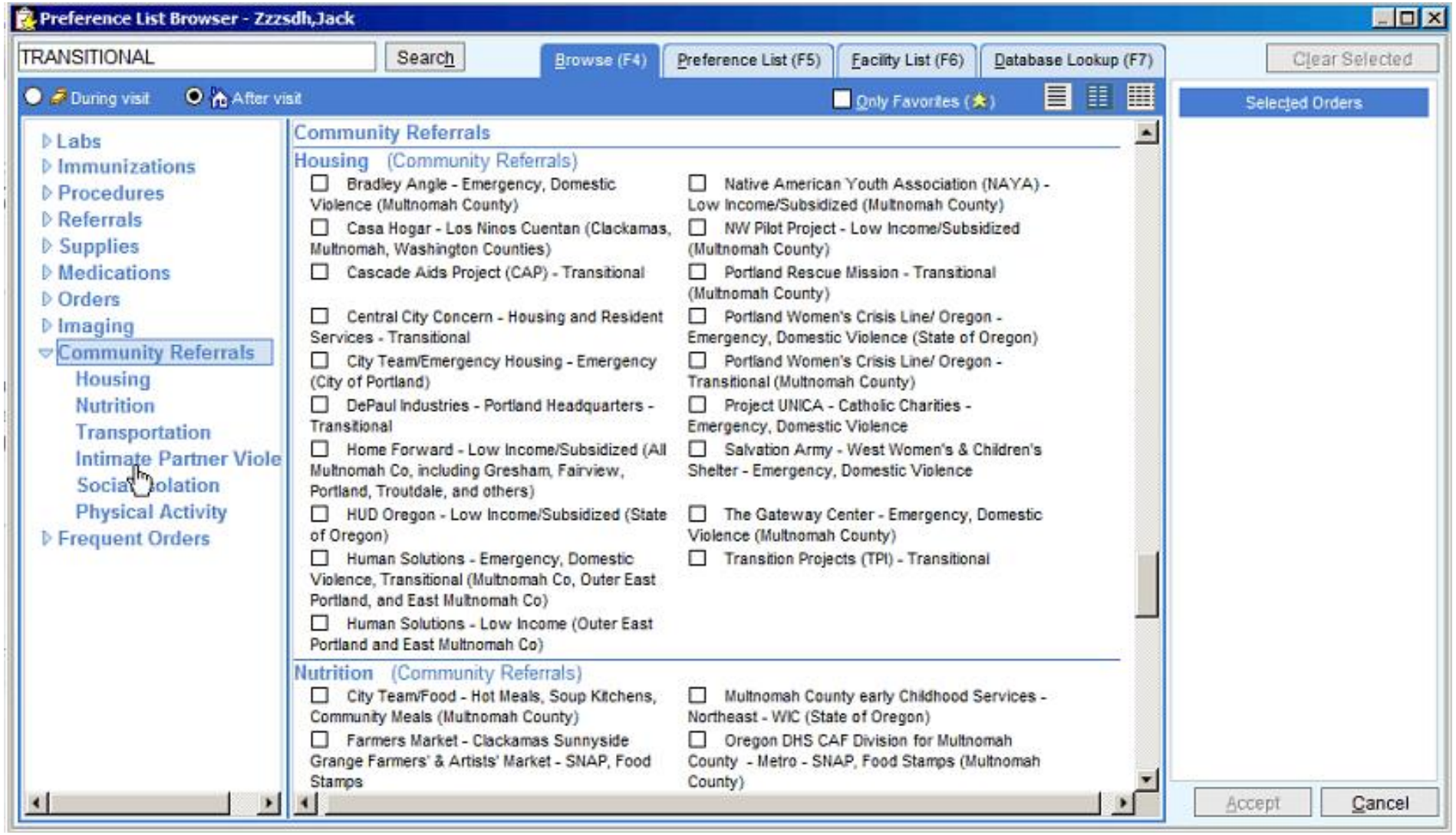
Add to SDH Problem List



Social Determinants on Problem List

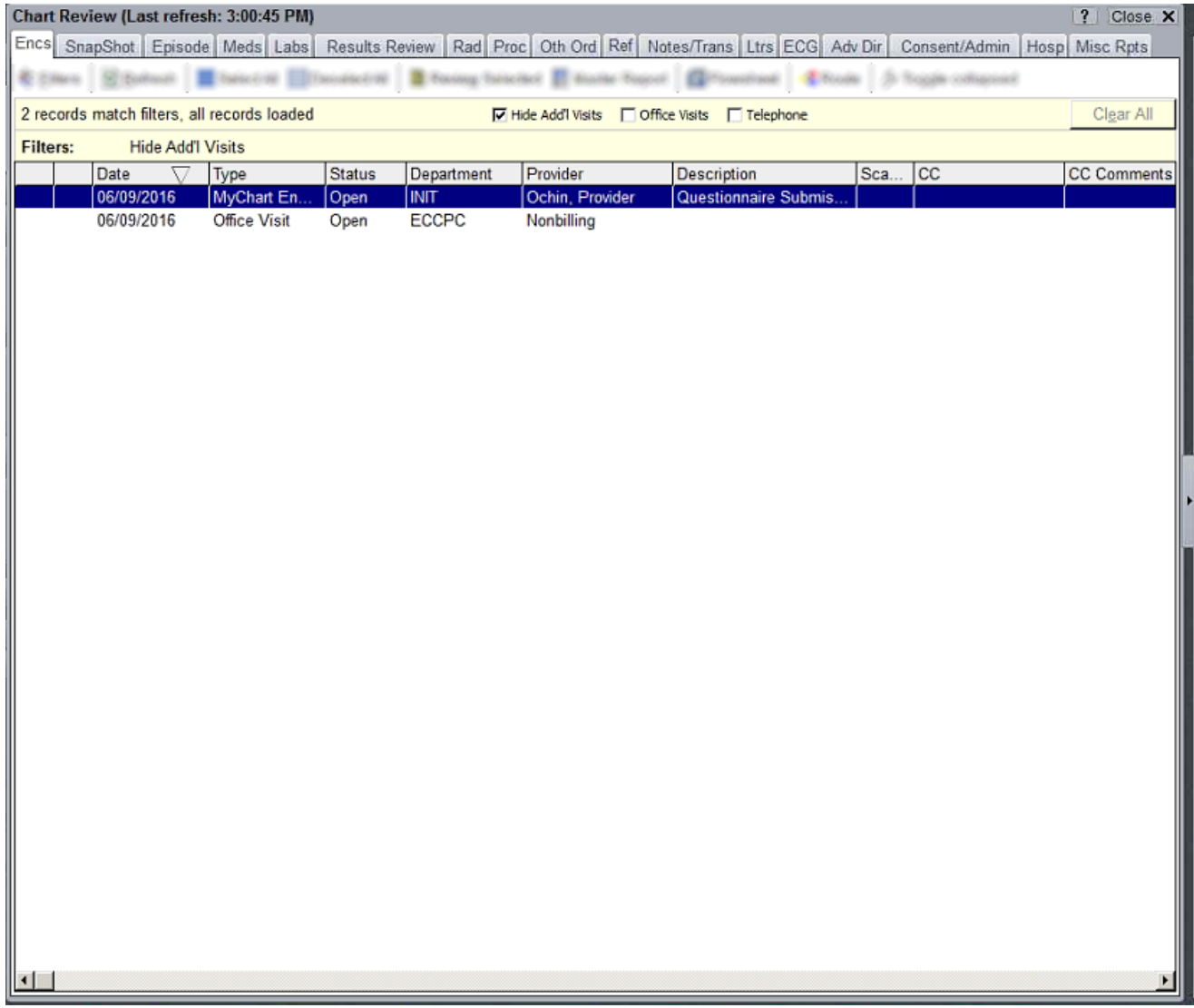


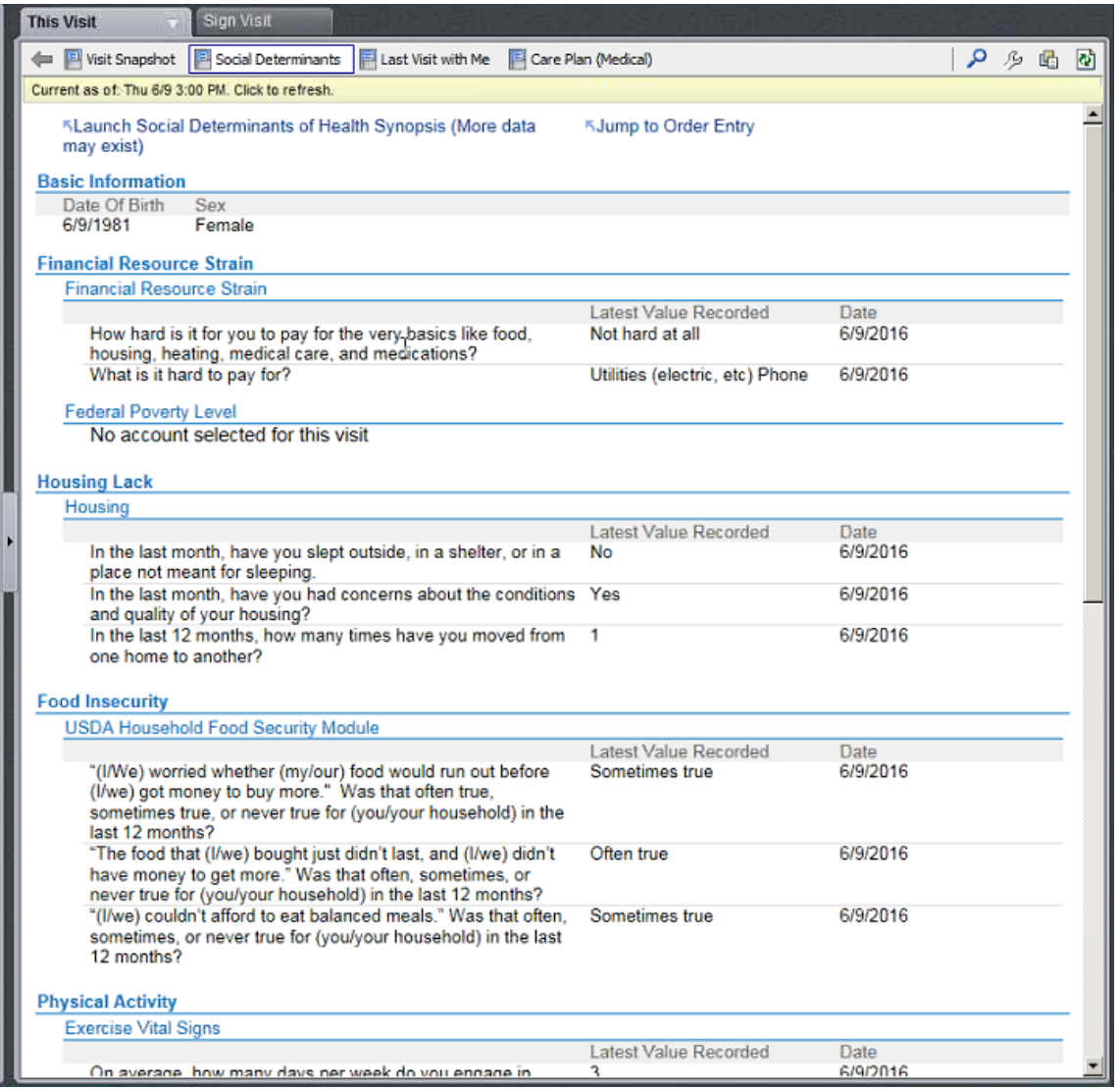
Ordering Referral to Community Services



SDH Questionnaire in MyChart Portal

MyChart Responses in SDH Summary Section





Order Referral linked to SDH Diagnosis on Problem List (Housing Lack)

Wrap-Up

Actions | Resize

Left | Patient Instructions | Comm Mgmt | Right | LOS | Follow-up | After Visit Summary | MyChart Sign-up | Validations | Sign Visit

Summary of Care Document

Patient Instructions (F3 to enlarge)

Bookmark

Insert SmartText

Your Referrals

Procedures	Refer to	Refer to Address	Refer to Phone Number
9545 - REFERRAL TO COMMUNITY SUPPORT SERVICES	HOME FORWARD,	135 SW ASH ST PORTLAND, OR 97204	503-802-8300

Instructions

Home Forward offers a variety of housing options to low-income individuals and families.

Communication Management

Letters

Level of Service

99211	99212	99213	99214	99215
99201	99202	99203	99204	99205

This Visit | Sign Visit

Visit Snapshot | Social Determinants | Last Visit with Me | Care Plan (Medical)

Current as of: Thu 6/9 3:03 PM. Click to refresh.

Launch Social Determinants of Health Synopsis (More data may exist)

Jump to Order Entry

Basic Information

Date Of Birth	Sex	Race	Ethnicity	Preferred Lang
6/9/1966	Male	Black	Non-Hispanic	English

Financial Resource Strain

Financial Resource Strain

Financial Resource Strain	Latest Value Recorded	Date
How hard is it for you to pay for the very basics like food, housing, heating, medical care, and medications?	Very hard	6/9/2016
Hard to pay for: Food	Yes	6/9/2016
Hard to pay for: Utilities	No	6/9/2016
Hard to pay for: Transportation	No	6/9/2016
Hard to pay for: Medicine or medical care	No	6/9/2016
Hard to pay for: Health insurance	Yes	6/9/2016
Hard to pay for: Clothing	No	6/9/2016
Hard to pay for: Rent/Mortgage payment	No	6/9/2016
Hard to pay for: Child care	No	6/9/2016
Hard to pay for: Phone	No	6/9/2016
Hard to pay for: Other	No	6/9/2016

Federal Poverty Level

No account selected for this visit

Housing Lack

	Codes	Priority	Class
Housing Problems (edg Social Determinants Of Health)			
Housing lack	ICD-9-CM: V60.0 ICD-10-CM: Z59.0		Social Determinants of Health

Overview Signed 6/9/2016 2:50 PM by Mary Middendorf

Jack has been moving all the time because he never gets along with his roommates and can't a place.

Housing

Housing	Latest Value Recorded	Date
In the last month, have you slept outside, in a shelter, or in a place not meant for sleeping?	No	6/9/2016
In the last month, have you had concerns about the conditions and quality of your housing?	No	6/9/2016

Reporting Workbench – Reports for Specific Positive Responses

MRN	Patient	DOB	Age	Sex	PCP	Last Housi	Last Housi
4091367	Zzz Boo Woo, Bear	09/03/1999	16 year old	Female	Englander, Wayne	1	5/5/2016
4105852	Zzzduck, Agnes	02/15/1971	45 year old	Female	Default, Mchd Provider	2	5/27/2016
4294077	Zzzmchd, Beeson Pni	02/14/1980	36 year old	Female	Fix, Mchd	3	5/26/2016
4325224	Zzz, Careplan	01/22/1961	55 year old	Female	Fix, Mchd	3	5/16/2016
4394183	Zzzfreeman, Notinjail	09/19/1982	33 year old	Female		1	5/20/2016
4394310	Zzztest, Mary2	06/07/1981	35 year old	Female		3	6/7/2016
4394311	Zzztest, Mary	06/07/1981	35 year old	Female		1	6/7/2016

Questions?

Ned Mossman
mossmann@ochin.org

Mary Middendorf
middendorfm@ochin.org