



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)?



- 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)

Adapted from www.HealthyPeople.gov

Examples of Social Determinants of Health (SDH)

Community-level factors

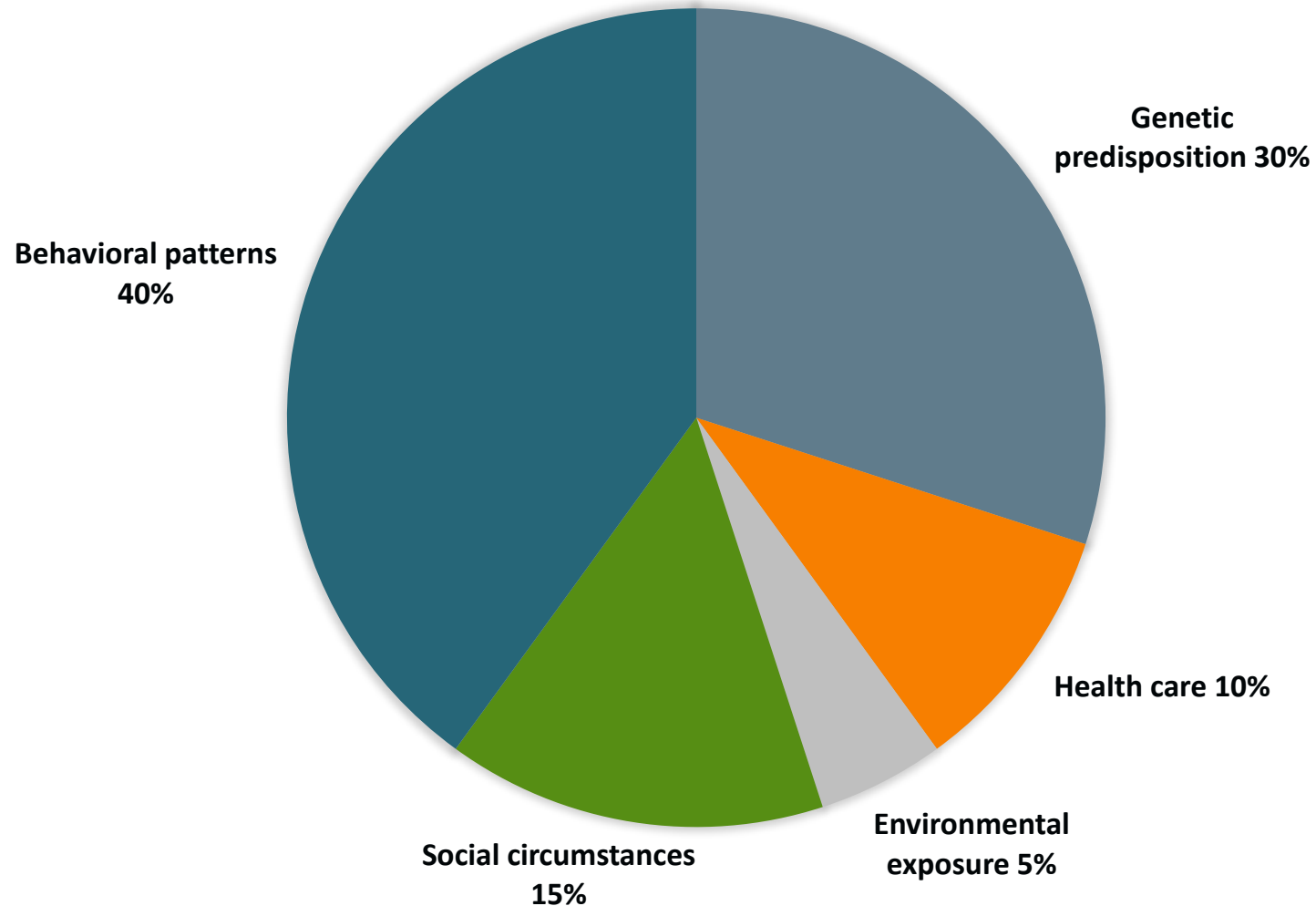
- *% of community living in poverty*
- *% high school or college graduates*
- *Built environment*
- *Walkability of neighborhood*
- *Crime*

Individual-level factors

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

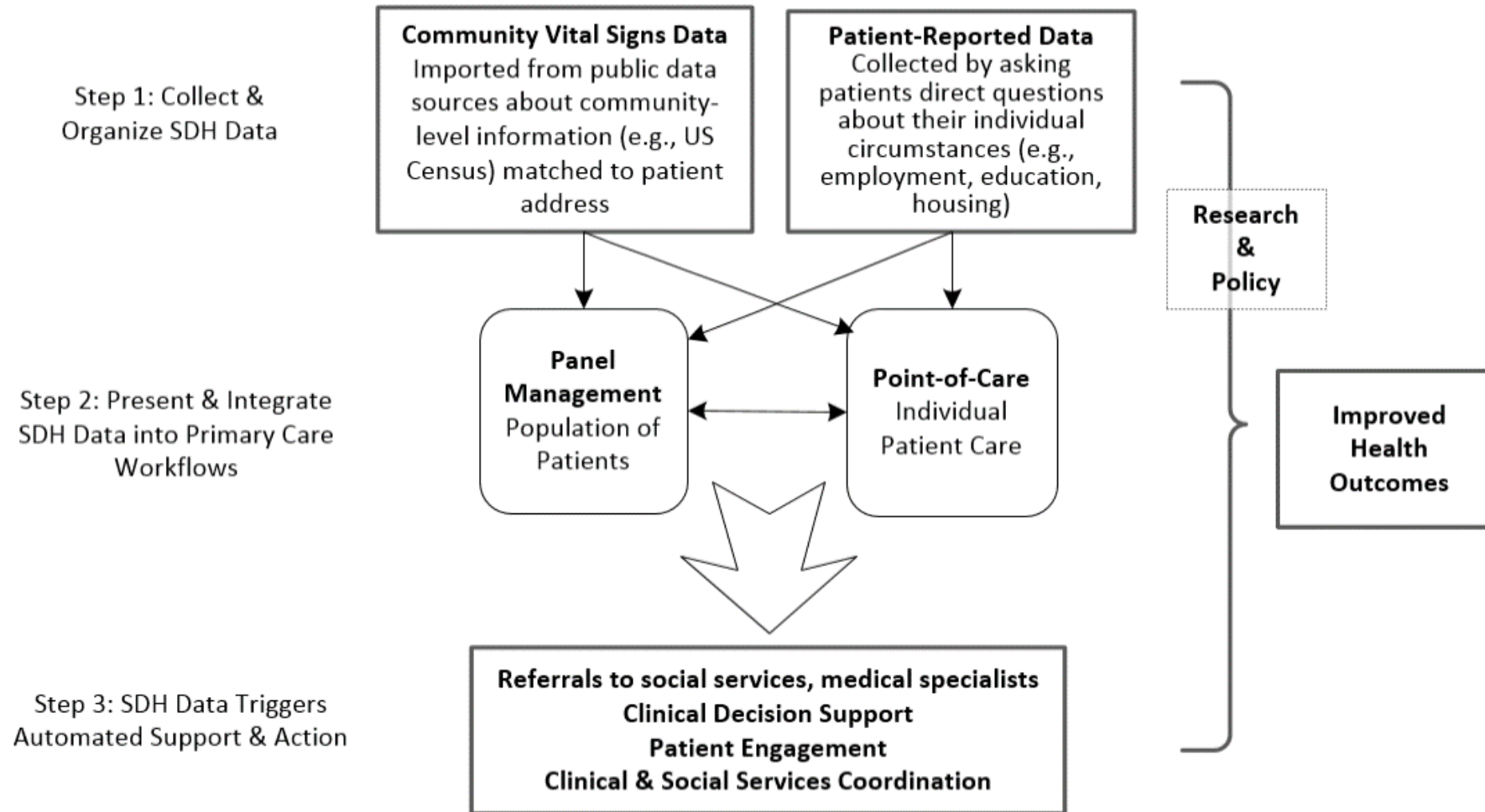
Why are SDH important in Primary Care?

PROPORTIONAL CONTRIBUTION TO PREMATURE DEATH



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?

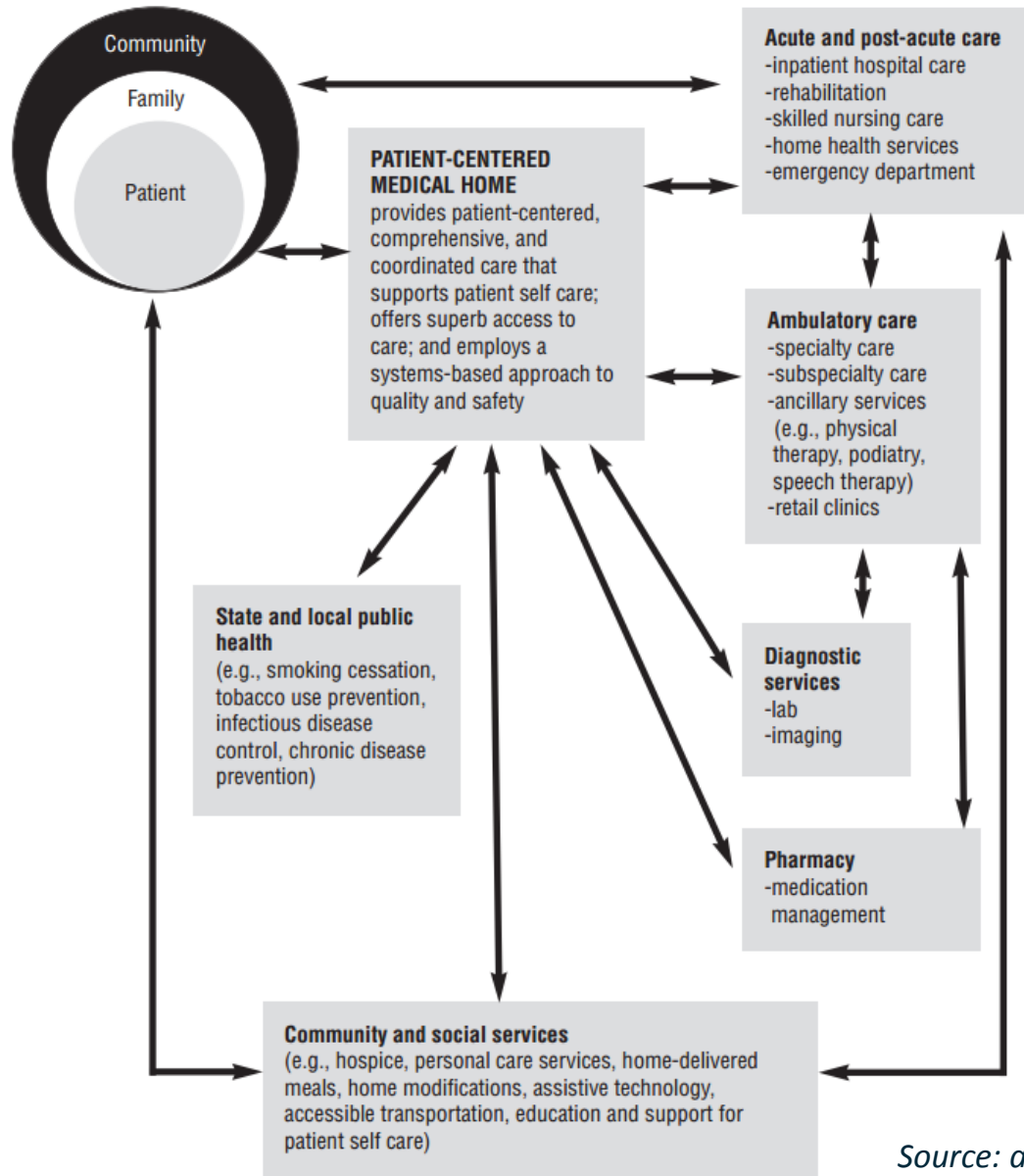
How can SDH be used in Community Health Centers?

- 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

Assumptions	Resources/Inputs	Activities	Outputs	Outcomes
PCMHs function as the core of the medical neighborhood Health is a community issue, and medical neighborhoods can impact community health Financial incentives may improve care coordination Effective use of health IT may improve flow of information across the neighborhood	Patients and their families Providers and health care systems Community and social service organizations State and local public health agencies Financial incentives by purchasers/payers Health IT Dedicated staff for care coordination Patient decision aids Community and social services Multi-payer databases	Clarify respective roles and responsibilities of clinicians in the system Facilitate and enhance information flow within the neighborhood Develop protocols for communication and coordination of patient care across providers (e.g., care coordination agreements) Engage in referral behaviors that promote good neighbor behavior Train providers in coordination, communication, and team-based care Systematize care coordination activities within the PCMH Educate patients on PCMH and the medical neighborhood, and their rights and responsibilities within it Promote the medical neighborhood concept through educational activities	Increased information flow among clinicians Improved (e.g., regular, timely) communication between clinicians Improved communication between clinicians and community/social services More appropriate referrals Increased accountability in terms of who is responsible for what Increased patient and family engagement; shared decisionmaking Increased clinician understanding of patient needs and preferences Increased use of public data (e.g., from multi-payer databases) to focus on population health	Short-term Improved care coordination Improved patient safety Improved patient experience Long-term Improved clinical outcomes Reduced costs through reduced duplication and waste Improved population health management

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

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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



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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

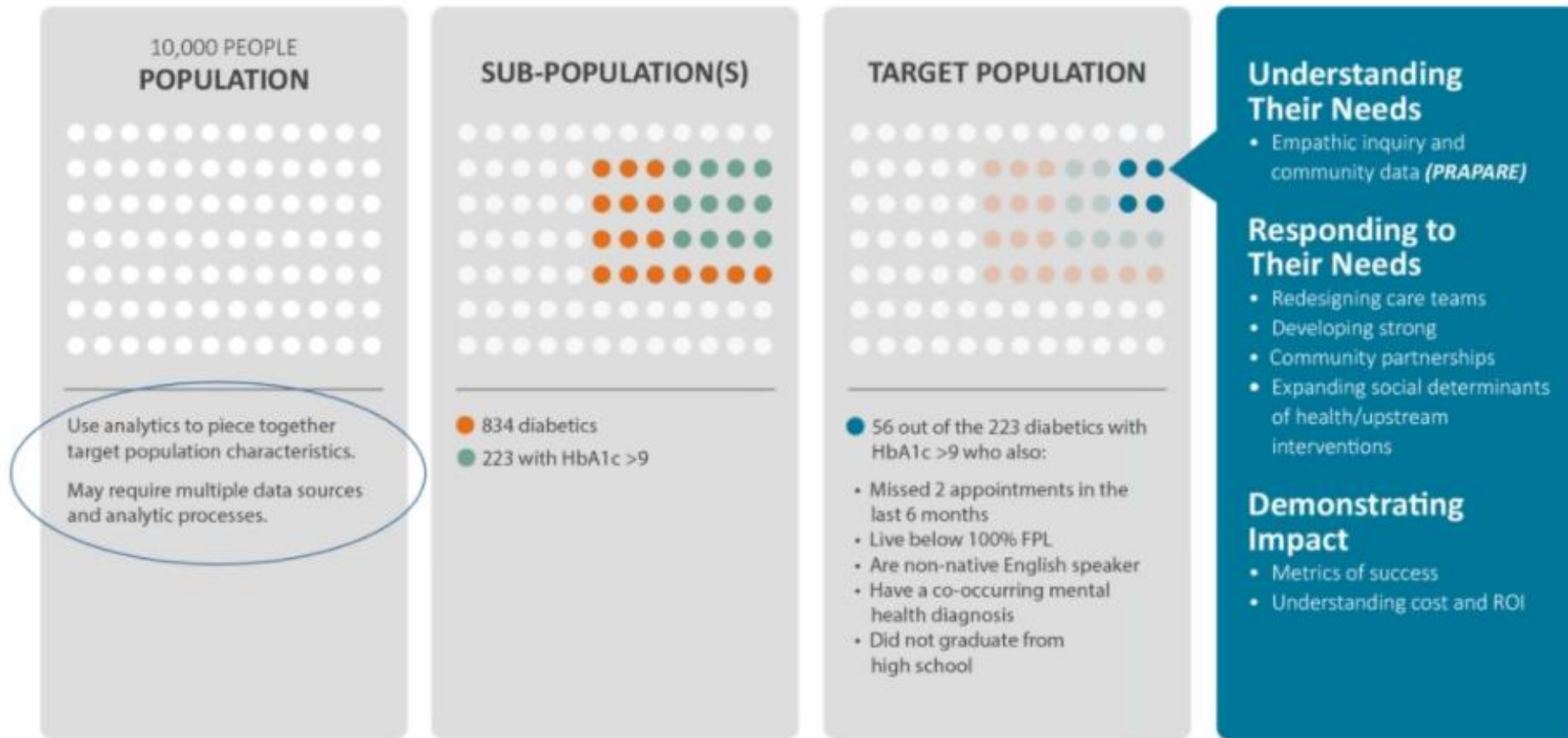


Illustration Courtesy of Oregon Primary Care Association



How the OCHIN SDH Tools Were Developed

National SDH Initiatives: PRAPARE, IOM Recommendations

NATIONAL ASSOCIATION OF Community Health Centers
AAPCHO
OPCA Oregon Primary Care Association
Institute for Alternative Futures

ASSESSING AND ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH USING PRAPARE:

PROTOCOL FOR RESPONDING TO AND ASSESSING PATIENTS' ASSETS, RISKS, AND EXPERIENCES

This project was made possible with funding from:

THE KRESGE FOUNDATION

blue of california foundation

KAISER PERMANENTE

- 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).

Domain	Measure ^a	Frequency
Race or ethnic group [†]	1. What is your race? 2. Are you of Hispanic, Latino, or Spanish origin?	At entry
Education	1. What is the highest level of school you have completed? 2. What is the highest degree you earned?	At entry
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: 1. Little interest or pleasure in doing things? 2. Feeling down, depressed, or hopeless?	Screen and follow up
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)? 2. On average, how many minutes do you engage in exercise at this level?	Screen and follow up
Tobacco use [‡]	1. Have you smoked at least 100 cigarettes in your entire life? If yes: 2. Do you now smoke cigarettes every day, some days, or not at all?	Screen and follow up
Alcohol use [‡]	1. How often do you have a drink containing alcohol? 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?	Screen and follow up
Social connection or isolation	1. In a typical week, how many times do you talk on the telephone with family, friends, or neighbors? 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?	Screen and follow up
Intimate-partner violence	1. Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner? 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?	Screen and follow up
Residential address [‡]	What is your current address?	Verify at every visit
Census-tract median income	Geocoded	Update on address change

^a 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?

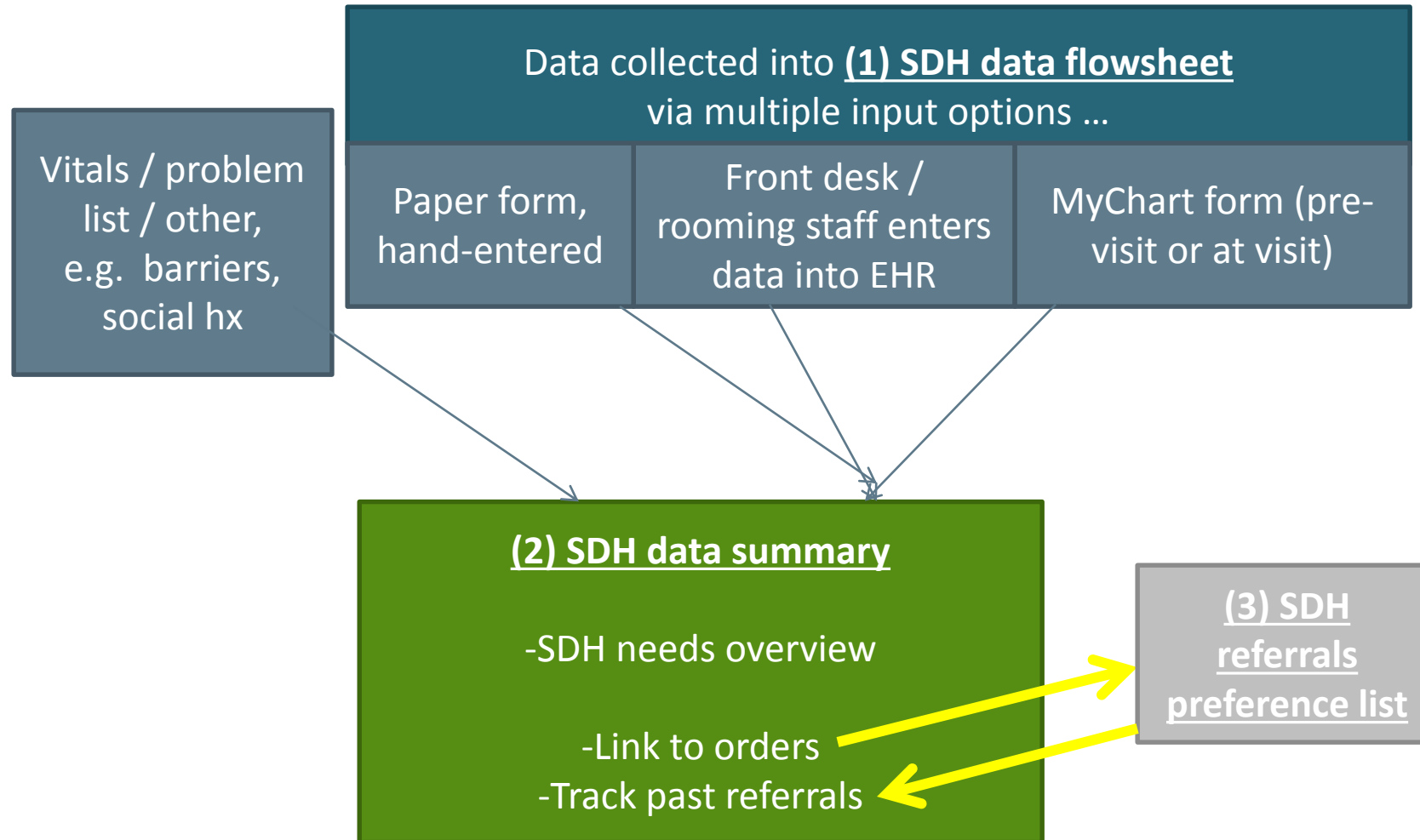
- Less than a high school diploma High school diploma / GED More than high school

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



Appt Search - Appt Dept SA Specific

▼ Matching reports

- ☆ Social Determinants of Health (SDH) - Visits in the Next Calendar Month (Login Department)

▶ Additional reports

Find Patients - Generic Criteria - SA Security

▼ Matching reports

- ☆ SDH: Exercise Vital Signs Minutes Per Week < 150 in Last 1 Year
- ☆ SDH: Financial Resource Strain filled out in last 1 year
- ☆ SDH: Financial Resource Strain Positive Response in Last 1 Year
- ☆ SDH: Food Insecurity Score > 1 or Balanced Meal Worry in Last 1 Year
- ☆ SDH: Housing Insecurity Score > 1 in Last 1 Year
- ☆ SDH: NHANES III Score < 3 or Lonely/Isolated or Lacks Access to Help in Last 1 Year
- ☆ SDH: Stress Positive Reponse in Last 1 Year
- ☆ SDH: Violence Exposure Positive in Last 1 Year

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Run Report and Send MyChart Portal Message

Sending request via MyChart to complete MyChart SDH Questionnaire

The screenshot shows the Epic Reports interface. At the top, there's a 'Reports' tab and a 'Scheduling Reports' sub-tab. Below that, a 'Temporary report setting [1957434] as of Thu 6/9/2016 1:52 PM' is displayed. A toolbar contains various icons like 'Filters', 'Options', 'Expand', 'Appts', 'Registration', 'Encounter', 'Communication', 'Check In', 'Check Out', 'Change', 'EQD', 'Edit Stats', 'Reg', 'Referrals', and 'Patient FYI'. A table lists patient records with columns for MRN, Patient, Dept, Prov/Res, Status, Pt. Portal Status, Last Learn, Last Education, and Last. A 'Communication' dropdown menu is open, showing options: 'Send Bulk Communication', 'Generate Letters', 'Send Patients Message', and 'Send Staff Message'. An orange arrow points from the 'Send Patients Message' option to a 'Questionnaire Details' dialog box. The dialog box has a 'Questionnaire' field with the value 'MYCHART SOCIAL DETERMINANTS OF HEALTH (SDH) [1000]' and a 'Display task to patient as:' field with the value 'Social Needs Questionnaire'. At the bottom of the dialog are 'Show Preview', 'Accept', and 'Cancel' buttons. The bottom of the screenshot shows a 'Social Determinants Summary' tab and two links: 'Launch Social Determinants of Health Synopsis (More data may exist)' and 'Jump to Order Entry'.

MRN	Patient	Dept	Prov/Res	Status	Pt. Portal Status	Last Learn	Last Education
4105852	Zzzduck, Agnes	ECCPC [60110013]	BRIGGS, KAREN N [63771]	Sch	Activated	Reading	Less than a high school degree
4394351	Zzzsdh, Jack	ECCPC [60110013]	BRIGGS, KAREN N [63771]	Sch	Activated	06/09/2016 2:00 PM OVS [1]	
4394352	Zzzshd, Eliza	ECCPC [60110013]	BRIGGS, KAREN N [63771]	Sch	Activated	06/09/2016 3:00 PM OVS [1]	

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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		


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Access to the SDH Flowsheet from Registration

The screenshot displays the Epic Registration interface for patient Zzzsdh, Jack. The top toolbar contains various icons, with the SDH icon (a blue square with a pencil) circled in red. The main window is titled "SDH" and shows the patient's registration status and demographic information. The patient's name is Zzzsdh, Jack, with a registration status of "Demographics". The patient is 50 years old, male, and has a phone number of 999-99-99. The registration was taken on 6/9/2016 at 14:39. The interface includes a left-hand navigation pane with options like "Demographics", "PCP/Employer", "Emergency Conta...", "Patient Messaging", "Additional Info", "Checklist", "Guarantor Accounts", and "Coverages". The main content area displays the SDH Flowsheet, which includes sections for "Education and Learning", "Financial Resource Strain", and "Housing". The "Education and Learning" section asks "How do you learn best?" (with options: Reading, Listening, Pictures) and "What is the highest level of school that you have finished?" (with options: Less than a high school diploma, High school diploma / GED, More than high school, I choose not to answer this question). The "Financial Resource Strain" section asks "How hard is it for you to pay for the very basics like food, housing, heating, medical care, and medications?" (with options: Not hard at all, Somewhat hard, Very hard). The "Housing" section asks "In the last month, have you slept outside, in a shelter, or in a place not meant for sleeping?" and "In the last month, have you had concerns about the conditions and quality of your housing?" (both with options: 1=Yes, 0=No, Declined). At the bottom of the SDH window are buttons for "Accept", "Accept and New", and "Cancel".

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Patient Schedule

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

Meds <input type="checkbox"/>	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	6/1/2016	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

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SDH Flowsheet in Patient Chart

Screenings - Screenings

Time taken: 1448 6/9/2016

Show: Row Info Last Filed Details All Choices

Values By

OTHER

Select combo screenings PHQ-SPRT-CRAFT Combo Social Determinants of Health

Select screenings Asthma Control Test AUDIT DAST Edinburgh Functional Status GAD-7 MCHAT-R Medicare HRA Mood Disorder Questionnaire PHQ-9
 STEADI Fall Risk Assessment TB Risk Assessment Vanderbilt Scores Vitals

Education and Learning

How do you learn best? Reading Listening Pictures

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 I choose not to answer this question

Financial Resource Strain

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

Housing

In the last month, have you slept outside, in a shelter, or in a place not meant for sleeping? 1=Yes 0=No Declined

In the last month, have you had concerns about the conditions and quality of your housing? 1=Yes 0=No Declined

In the last 12 months, how many times have you moved from one home to another? Housing Insecurity Score
 2 or more moves flagged for follow-up. Number of positive responses to housing questions.

Food Security

"(I/We) worried whether (my/our) food would run out before (I/we) got money to buy more." Was that often true, sometimes true, or never true for (you/your household) in the last 12 months? 2=Often true 1=Sometimes true 0=Never true Don't know or Refused

"The food that (I/we) bought just didn't last, and (I/we) didn't have money to get more." Was that often, sometimes, or never true for (you/your household) in the last 12 months? 2=Often true 1=Sometimes true 0=Never true Don't know or Refused

"(I/we) couldn't afford to eat balanced 2=Often true 1=Sometimes true 0=Never true Don't know or Refused

SDH Summary in Patient Chart

This Visit | Sign Visit

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

Current as of: Thu 6/9 2:48 PM. Click to refresh.

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

Housing

	Latest Value Recorded	Date
Housing		
In the last month, have you slept outside, in a shelter, or in a place not meant for sleeping?	Yes	6/9/2016
In the last month, have you had concerns about the conditions and quality of your housing?	Yes	6/9/2016
In the last 12 months, how many times have you moved from one home to another?	5	6/9/2016
Housing Insecurity Score	3	6/9/2016

Food Insecurity

USDA Household Food Security Module

	Latest Value Recorded	Date
Food Security		
"(I/We) worried whether (my/our) food would run out before (I/we) got money to buy more." Was that often true, sometimes true, or never true for (you/your household) in the last 12 months?	Often true	6/9/2016
"The food that (I/we) bought just didn't last, and (I/we) didn't have money to get more." Was that often, sometimes, or never true for (you/your household) in the last 12 months?	Never true	6/9/2016
"(I/we) couldn't afford to eat balanced meals." Was that often, sometimes, or never true for (you/your household) in the last 12 months?	Don't know or Refused	6/9/2016
USDA 2Q Score	1	6/9/2016

Intimate Partner Violence

Add to SDH Problem List

ID	Name	Code	Code Set
V60.4.ICD-9-CM	HOUSEHOLD MEMBER (aka No other household member able to render care)	Z74.2	ICD-10-CM
247853	Housing lack	Z59.0	ICD-10-CM
V60.0.ICD-9-CM	Lack of housing	Z59.0	ICD-10-CM
1475627	Lack of running water in house	Z91.89	ICD-10-CM

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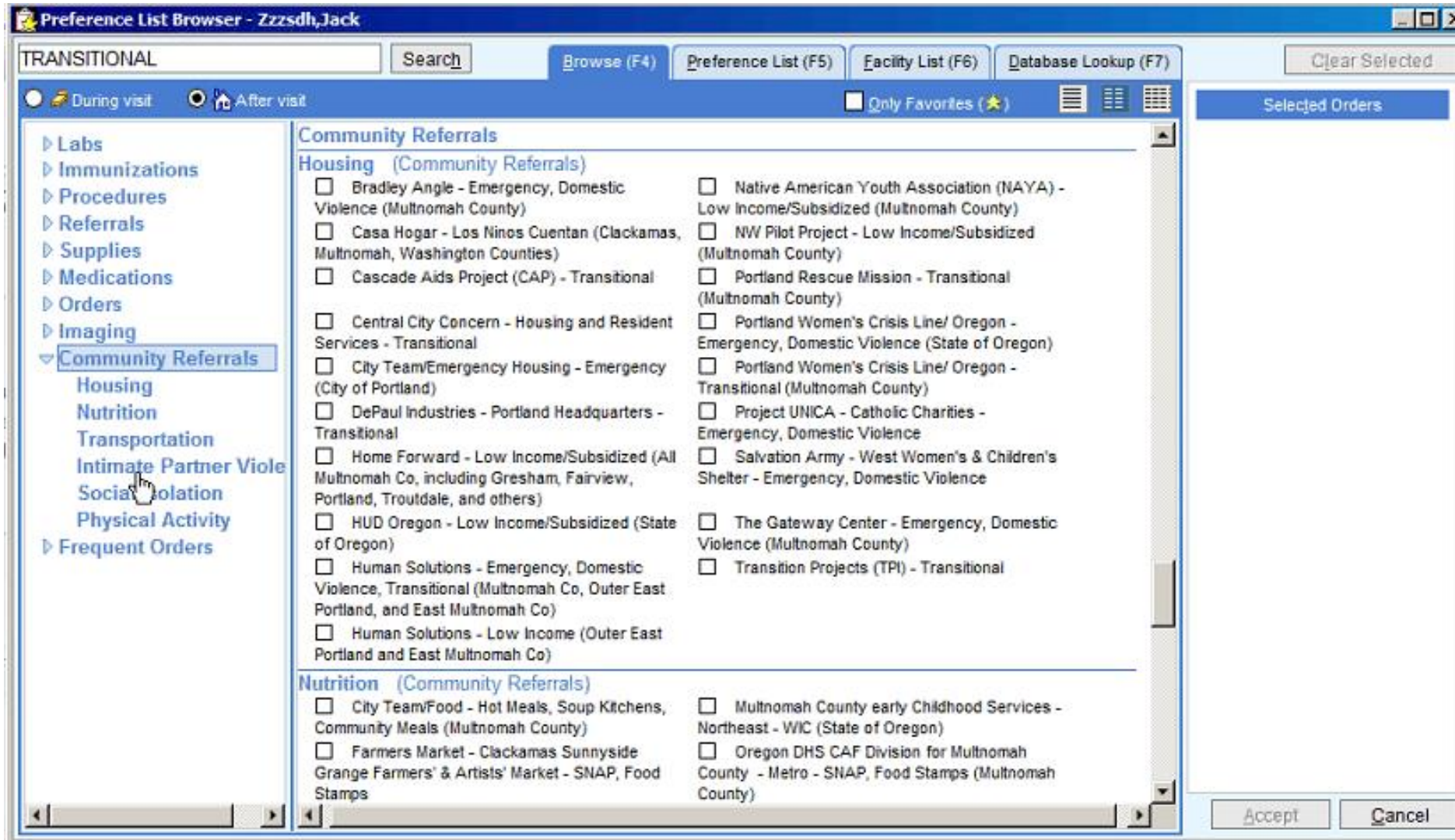
Social Determinants on Problem List

The screenshot displays the Epic Problem List interface. At the top, there is a header "Problem List" with a pencil icon. Below it, there are several action buttons: "Create Patient Care Coordination Note" (with a plus icon), "Add a new problem" (with a plus icon and "Add" button), "DxReference" (with a magnifying glass icon), "Show: Past Problems", and "Options" (with a gear icon). The "List view" section includes radio buttons for "Class", "Do not group", "Episode", "Priority", "Status", and "System" (which is selected). There is also a "Choose Columns" button. Below this, there are two dropdown menus: "Overview Preview: One Line" and "Assessment & Plan Note Preview: None". To the right of these are checkboxes for "Show: Deleted" and " Empty Systems".

The main content area shows a search bar with "Diagnosis" and a "Sort Priority" button. Below this, there is a section titled "Social Determinants of Health" with a plus icon and "Create Current Assessment & Plan Note" button. A specific problem is listed: "Housing lack" (with a right-pointing arrow icon). To the right of this problem are icons for "Edit Notes", "Unprioritized", and "Today", along with the name "Middendorf, Mary". Below the problem name is an "Overview" icon and a text description: "Jack has been moving all the time because he never gets along with his roommates and can't afford his own place." At the bottom of the interface, there are buttons for "Mark as Reviewed" (with a checkmark icon) and "Never Reviewed".

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Ordering Referral to Community Services



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SDH Questionnaire in MyChart Portal



The screenshot shows a web browser window displaying the MyChart portal. The URL in the address bar is <http://mychartrel.ochin.info/mychartrel/inside.asp?mode=questionnaire&mid=1&ta>. The page header features the OCHIN mychart logo and a user profile for Eliza Zzzshd with a Log Out button. A navigation bar includes links for Messaging, Visits, My Medical Record, Billing, and Preferences. The main content area is titled "Social Needs Questionnaire" and includes an introductory paragraph: "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. They will be entered into your medical record, and, as with all medical information, will always be kept private and confidential." The questionnaire is divided into sections: "Education and Learning" with questions about learning preferences (Reading, Listening, Pictures) and highest school level (Less than a high school diploma, High school diploma / GED, More than high school); "Financial Resource Strain" with a question about the difficulty of paying for basics (Not hard at all, Somewhat hard, Very hard) and a list of items that are hard to pay for (Food, Housing, Utilities, Childcare, Medical needs, Transportation, Phone, Clothing, Other).

MyChart Responses in SDH Summary Section

Chart Review (Last refresh: 3:00:45 PM) ? Close X

Encs [SnapShot](#) [Episode](#) [Meds](#) [Labs](#) [Results Review](#) [Rad](#) [Proc](#) [Oth Ord](#) [Ref](#) [Notes/Trans](#) [Ltrs](#) [ECG](#) [Adv Dir](#) [Consent/Admin](#) [Hosp](#) [Misc Rpts](#)

2 records match filters, all records loaded Hide Add'l Visits Office Visits Telephone [Clear All](#)

Filters: Hide Add'l Visits

Date	Type	Status	Department	Provider	Description	Sca...	CC	CC Comments
06/09/2016	MyChart En...	Open	INIT	Ochin, Provider	Questionnaire Submis...			
06/09/2016	Office Visit	Open	ECCPC	Nonbilling				

This Visit [Sign Visit](#)

[Visit Snapshot](#) [Social Determinants](#) [Last Visit with Me](#) [Care Plan \(Medical\)](#)

Current as of: Thu 6/9 3:00 PM. [Click to refresh.](#)

[Launch Social Determinants of Health Synopsis \(More data may exist\)](#) [Jump to Order Entry](#)

Basic Information

Date Of Birth	Sex
6/9/1981	Female

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?	Not hard at all	6/9/2016
What is it hard to pay for?	Utilities (electric, etc) Phone	6/9/2016

Federal Poverty Level

No account selected for this visit

Housing Lack

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?	Yes	6/9/2016
In the last 12 months, how many times have you moved from one home to another?	1	6/9/2016

Food Insecurity

USDA Household Food Security Module

USDA Household Food Security Module	Latest Value Recorded	Date
"(I/We) worried whether (my/our) food would run out before (I/we) got money to buy more." Was that often true, sometimes true, or never true for (you/your household) in the last 12 months?	Sometimes true	6/9/2016
"The food that (I/we) bought just didn't last, and (I/we) didn't have money to get more." Was that often, sometimes, or never true for (you/your household) in the last 12 months?	Often true	6/9/2016
"(I/we) couldn't afford to eat balanced meals." Was that often, sometimes, or never true for (you/your household) in the last 12 months?	Sometimes true	6/9/2016

Physical Activity

Exercise Vital Signs	Latest Value Recorded	Date
On average, how many days per week do you engage in	3	6/9/2016

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



Wrap-Up

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

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 Language
6/9/1966	Male	Black	Non-Hispanic	English

Financial Resource Strain

Financial Resource Strain	Latest Value Recorded	Date
Financial Resource Strain		
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

Housing Problems (edg Social Determinants Of Health)	Codes	Priority	Class
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 find a place.

Housing

Housing	Latest Value Recorded	Date
Housing		
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



The screenshot shows a web application window with three tabs: 'Zzzshd,Eliza', 'Zzzsdh,Jack', and 'Reports'. The main content area displays a report titled 'SDH: Housing Insecurity Score > 1 in Last 1 Year [1957432] as of Thu 6/9/2016 1:51 PM'. Below the title is a navigation bar with various icons and a 'Bulk Orders' button. The main data is presented in a table with the following columns: MRN, Patient, DOB, Age, Sex, PCP, Last Housi, and Last Housi. The first row is highlighted in blue and shows a score of 1 for patient 'Zzz Boo Woo, Bear'. Other rows show scores of 2, 3, 3, 1, 3, and 1 for various other patients.

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

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Questions?



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