



Caring for the Whole Patient:

Using Health IT to Address Social Determinants of Health

This webinar is funded by grants from:



Neither Connecticut Office of Health Strategy nor Connie had undue influence on the content of this program.



New CME Series – with CPE sought as appropriate

Health Information Technology for Clinicians:
How to Achieve Optimal Outcomes

Webinars and In-person events



Activity Director/Moderator: Thomas Agresta MD, MBI

Department of Family Medicine, Center for Quantitative Medicine

UConn Health

UConn
HEALTH

Health Information Technology for Clinicians: How to Achieve Optimal Outcomes

Sample Topics

- Medication Safety/ Reconciliation
- Precision Medicine
- Health Data Analytics
- Health Information Exchange
- eCQMs (electronic clinical quality measures)
- Patient Consent models
- Telehealth
- Public Health Informatics
- Patient-Generated Data

Housekeeping



All participant lines will be muted during the panel discussion



The panelist will address your questions during the Q/A session from the Q/A chat feature



If we are not able to address your question today, we will follow up with you directly using your registered email.



This session will be recorded and available for download along with the slides used today.



Instructions on how to access will be sent after the session to your registered email along with instructions to earn CME and CPE credit.

Presenters

David Henderson, MD



**Associate Dean,
Multicultural & Community Affairs
UConn Health**

Tekisha Everette, PhD



**Executive Director
Health Equity Solutions**

Jacob Reider, MD



**Chief Executive Officer
Alliance for Better Health**

Disclosures: All presenters have reported they have no conflicts to disclose

Learning objectives

1

Discuss the benefits of the collection and utilization of Social Determinants of Health (SDOH) data on improving health outcomes

2

Describe how SDOH can help providers recognize and treat the underlying causes that impact individual and population health

3

Identify challenges and best practices to collection and use of SDOH data

4

Discuss the tools and solutions available to address SDOH



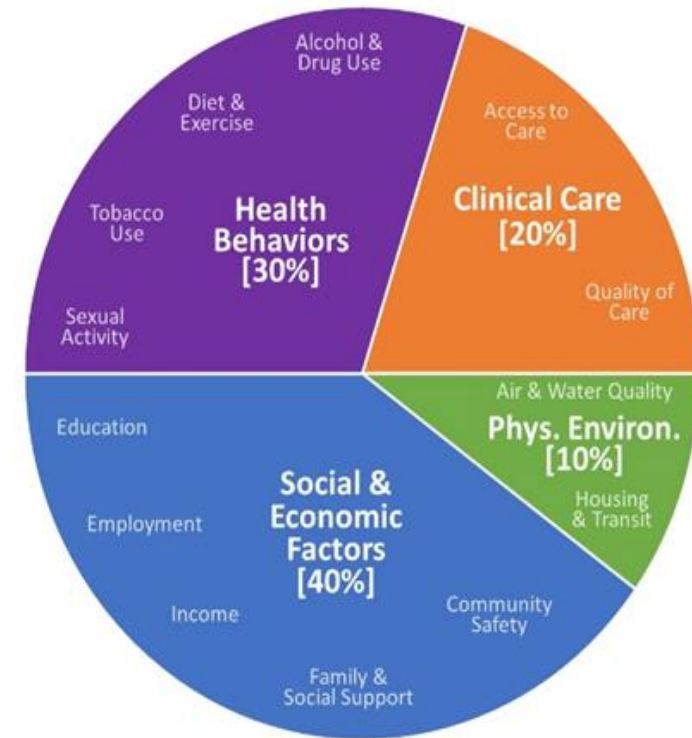
DEFINITIONS



Defining Health

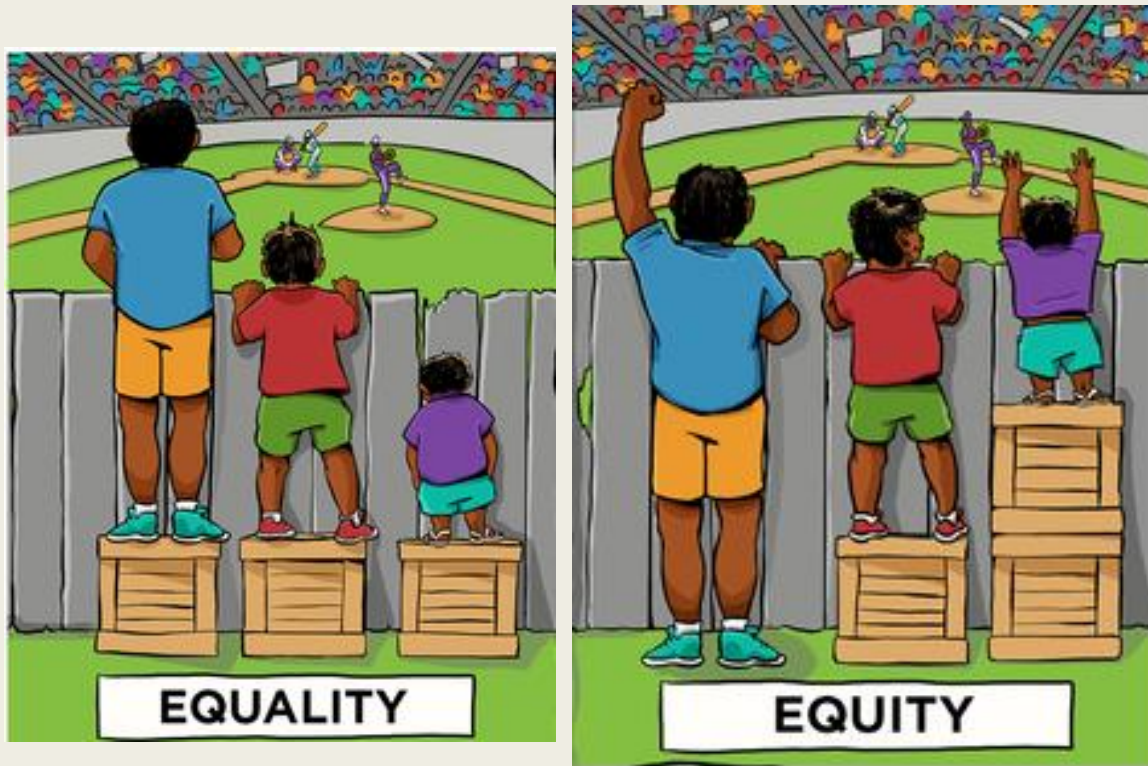
Health – “is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” –
World Health Organization

Chart 1: The Factors Affecting Health Outcomes



Source: Adapted from the University of Wisconsin's *County Health Rankings* model (2014)

What Is Health Equity...



- Everyone has a fair & just opportunity to attain optimal health
- Involves learning & understanding community need
- Beyond understanding requires real action to remove/dismantle barriers to resources

Story Based Strategy
<http://www.storybasedstrategy.org/blog/the4thbox>

Health Equity

- **Health equity** – everyone has the opportunity to attain optimal health regardless of race, ethnicity, gender, income level or other social factors that create barriers to health.





**SOCIAL
DETERMINANTS OF
HEALTH**



Social Determinants of Health

“The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.”

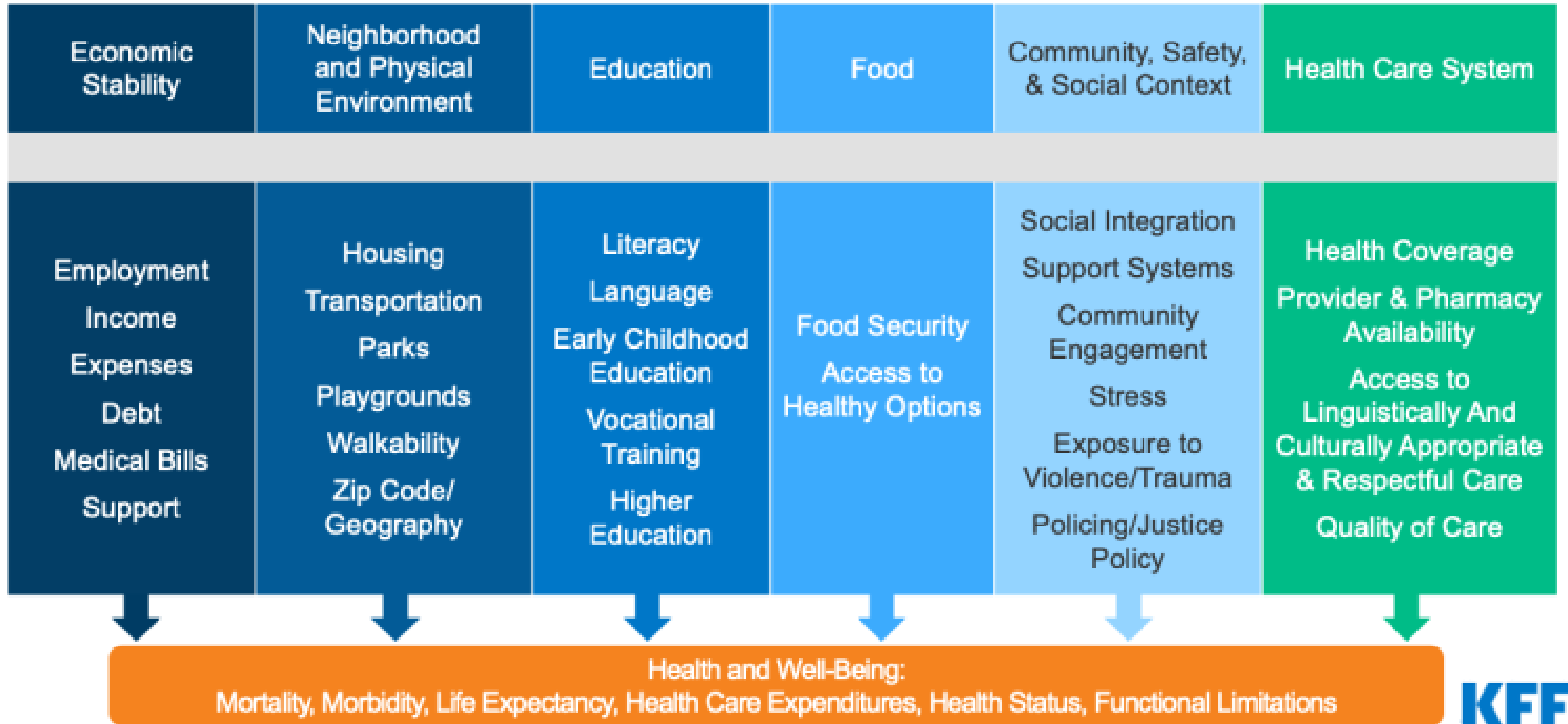


World Health Organization

http://www.who.int/social_determinants/sdh_definition/en/

Figure 1

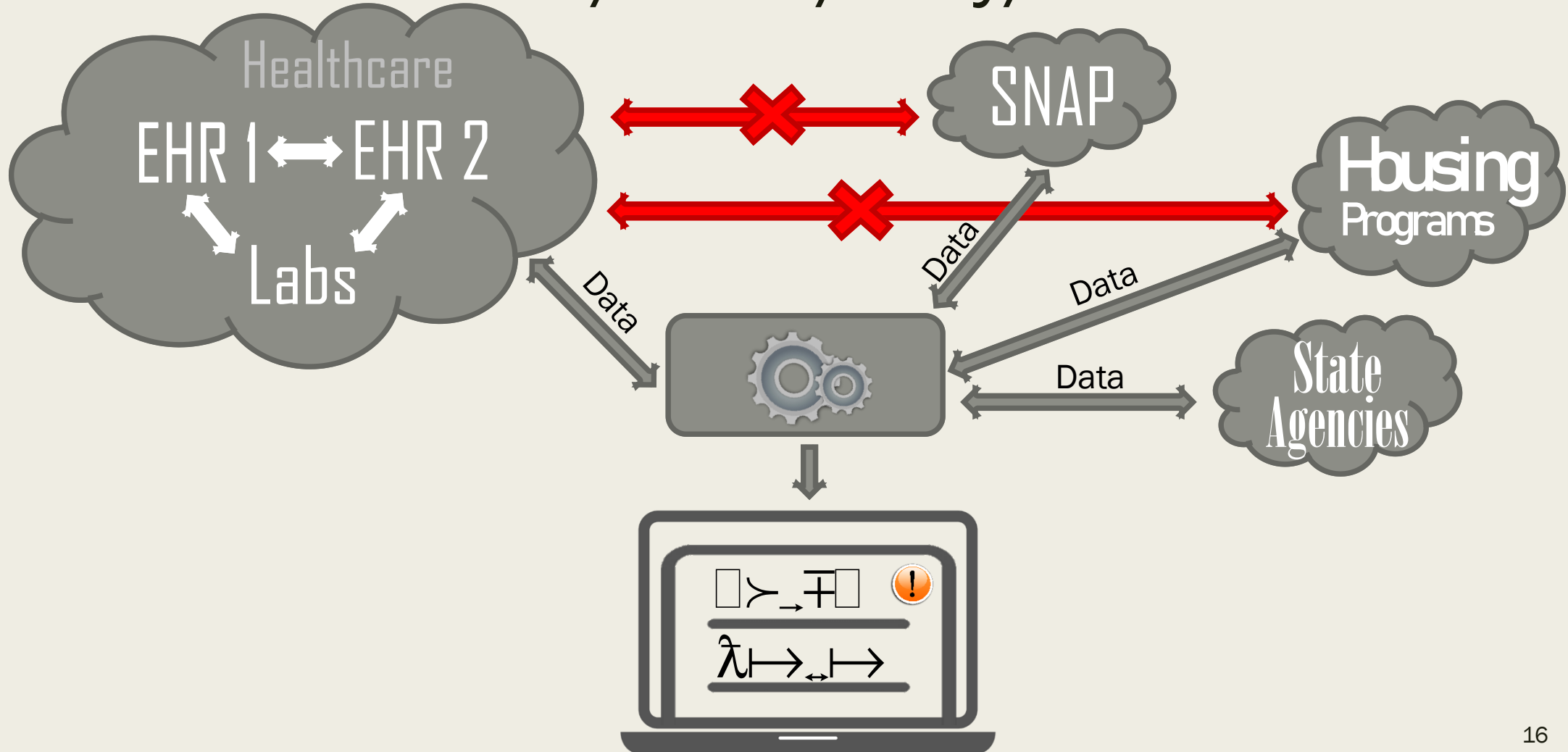
Social Determinants of Health



Why is this Important?

- The factors that make up our individual and community health impact *all* of us, *all* the time
- While it impacts everyone, we're not all impacted in the same way
- These determinants do not happen by accident

SDOH & Health IT: Who/What/Why/How



On Our Way To...



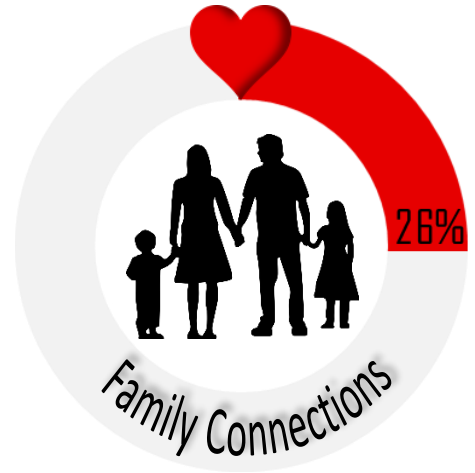
Story Based Strategy
<http://www.storybasedstrategy.org/blog/the4thbox>

Social Determinants of Health in Health Care Delivery

David Henderson, MD
Professor, and Chair of Family Medicine
Associate Dean for Multicultural and Community Affairs



“Social Determinants of Health”



Social Determinants of Health



Previous Medical School Teachings



Social Determinants of Health in Health Care Delivery

The screenshot displays a medical software interface with a navigation bar at the top containing tabs for Snapshot, Chart Review, Review Flowsheets, Results Review, Synopsis, History, Allergies, Problem List, Medications, Immunizations, Demographics, Patient Station, and Encounter. The 'History' tab is active, and a 'Review Social Determinants' window is open. The window title is 'Review Social Determinants' and it includes a 'Close Review Social Determinants' button. The main content area is titled 'Social Determinants of Health' and lists several categories with their respective status and dates:

- Financial Resource Strain**: Aug 12 2020: Low Risk
- Transportation Needs**: Aug 12 2020: No Transportation Needs
- Housing Stability**: Not on file
- Food Insecurity**: Aug 12 2020: No Food Insecurity
- Social Connections**: Aug 12 2020: Moderately Isolated

At the bottom of the window, there are 'Previous' and 'Next' navigation buttons. The left sidebar of the software shows a navigation menu with categories like GENERAL (Medical, Surgical, Family), SOCIAL DETERMINANTS (Substance Use, E-cigarette/Vaping, Sexual Activity, Socioeconomic, Social Determinants, Social Documentation), and SPECIALTY (Birth, Obstetrics). The 'Social Determinants' category is currently selected.



Social Determinants of Health in Health Care Delivery

History

GENERAL
Medical
Surgical
Family

SOCIAL DETERMINANTS
Substance Use
E-cigarette/Vaping
Sexual Activity
Socioeconomic
Social Determinants
Social Documentation

SPECIALTY
Birth
Obstetrics

Review Social Determinants

♥ Social Determinants of Health

- Financial Resource Strain**
Aug 12 2020: Low Risk
- Transportation Needs**
Aug 12 2020: No Transportation Needs
- Housing Stability**
Not on file

Food Insecurity
Aug 12 2020: No Food Insecurity

May 1, 2018 — Today

Aug 12, 2020: No Food Insecurity
Worried About Running Out of Food in the Last Year
Never true
Ran Out of Food in the Last Year
Never true

Social Connections
Aug 12 2020: Moderately Isolated

May 1, 2018 — Today

Aug 12, 2020: Moderately Isolated

Frequency of Communication with Friends and Family
More than three times a week

Frequency of Social Gatherings with Friends and Family
Once a week

Attends Religious Services
1 to 4 times per year

Active Member of Clubs or Organizations
No

Attends Club or Organization Meetings
Never

Marital Status
Never married



Food Insecurity Report

Microsoft Excel interface showing a spreadsheet with columns for Patient, PCP, PCP Dept, Last BMI, Age, Gender, and Food Insecurity status. A 'Tell Me (Alt+Q)' tooltip is visible over the Age column.

Patient	PCP	PCP Dept	Last BMI	Age	Gender	Food Insecurity
1						
2		AHFM PUF	25.8	54 y.o.	Female	Activated
3		AHFM PUF	36.5	60 y.o.	Female	Not Used
4		AHFM PUF	36.6	28 y.o.	Female	Activated
5		AHFM PUF	26.9	55 y.o.	Male	Not Used
6		AHFM PUF	26.4	54 y.o.	Male	Not Used
7		AHFM PUF	40.3	37 y.o.	Male	Activated
8		AHFM PUF	35.4	53 y.o.	Male	Activated
9		AHFM PUF	19.8	29 y.o.	Female	Activated
10		AHFM PUF	33.6	62 y.o.	Female	Activated
11		AHFM PUF	21.7	59 y.o.	Male	Activated
12		AHFM PUF	29.3	51 y.o.	Female	Activated
13		AHFM PUF	20.5	19 y.o.	Male	Not Used
14		AHFM PUF	32.5	30 y.o.	Male	Activated
15		AHFM PUF	37.4	56 y.o.	Female	Activated
16						
17		AHFM PUF	23.5	84 y.o.	Male	Not Used
18		AHFM PUF	22	20 y.o.	Male	Not Used
19		AHFM PUF	27.8	52 y.o.	Female	Activated
20		AHFM PUF	34	68 y.o.	Female	Not Used
21						
22		AHFM PUF	28.4	66 y.o.	Male	Activated
23		AHFM PUF	32	61 y.o.	Female	Activated
24		AHFM PUF	26.5	58 y.o.	Male	Activated
25		AHFM PUF	21.5	69 y.o.	Male	Activated
26		AHFM PUF	25.8	57 y.o.	Male	Activated
27		AHFM PUF	39.9	20 y.o.	Female	Activated
28		AHFM PUF	24.8	71 y.o.	Male	Activated
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SDOH Data Collection and Use

Workflow

Data collected
by nurse/MA

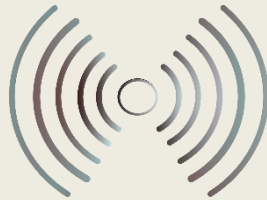


Reviewed by
provider

Data Use



Foster collaboration
within
interprofessional
care teams



Facilitate
communication
related to
interventions



Document
progress toward
resolution



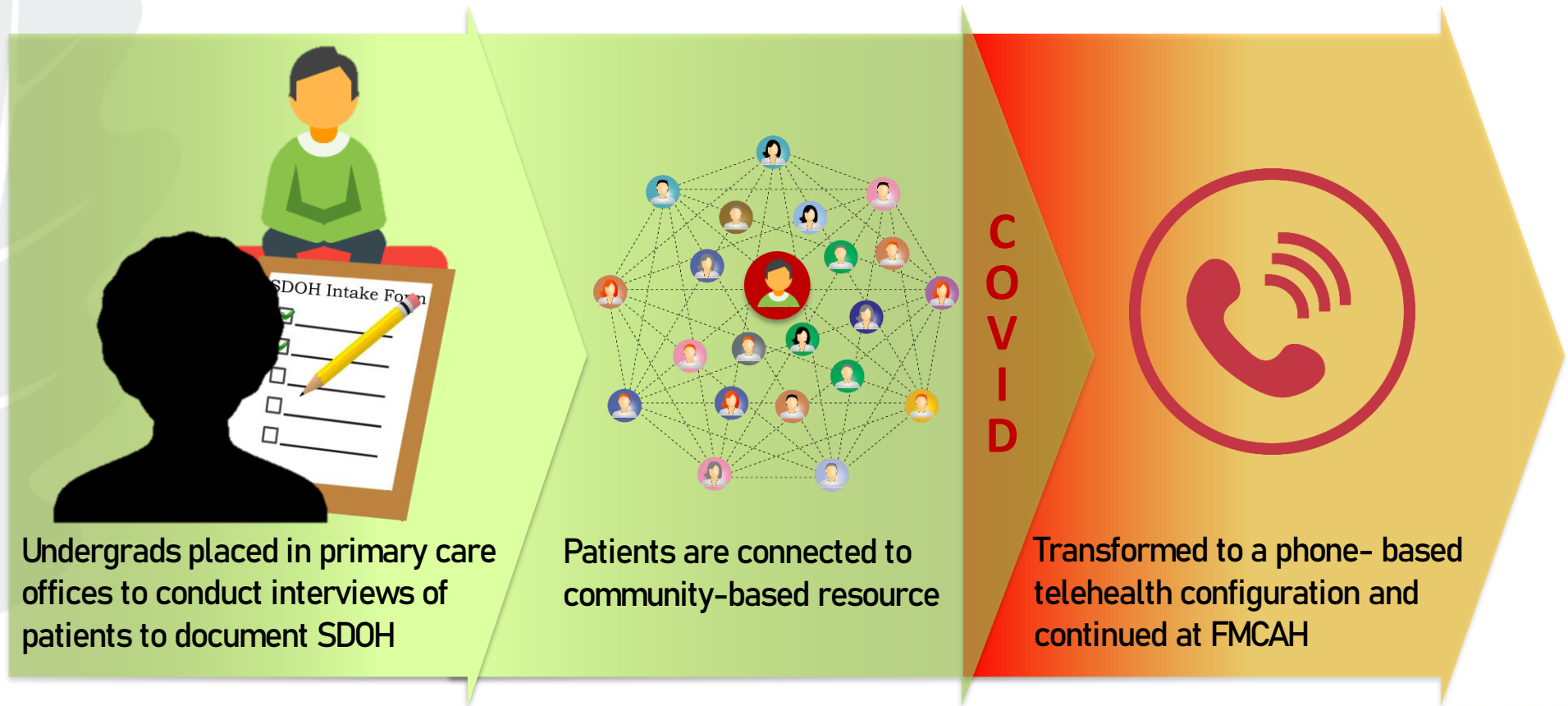
Facilitate
community-based
healthcare
delivery



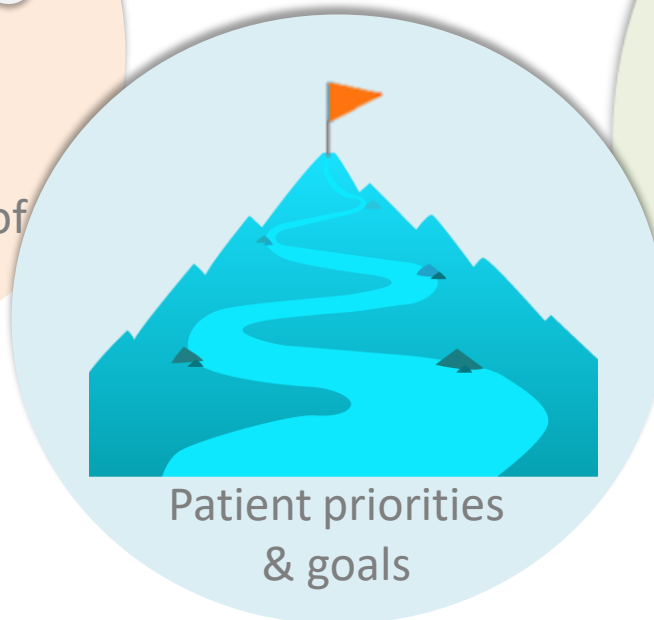
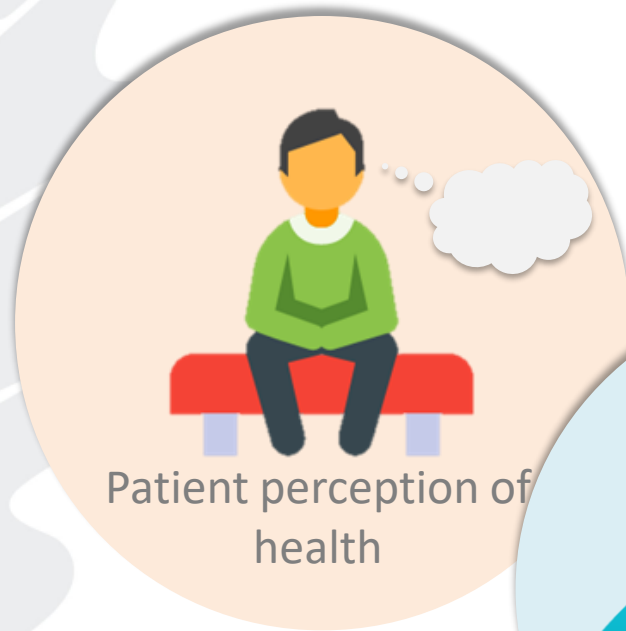
Share aggregated
data with DPH and
community
partners




UConn Health Leaders



New SDOH Informed History – “360 H&P” (AMA ACE Consortium)




Opportunities and Challenges




The icon depicts a yellow house with a red roof and a chimney. A blue caduceus symbol is on the roof, and 'MD' is written on the door. A green arrow curves from the top right to the top left, and another green arrow curves from the bottom left to the bottom right, forming a loop around the house.

Practice Transformation



The icon shows a person in a dark suit standing at a brown desk, pointing at a green chalkboard. The chalkboard has 'UME & GME' written on it. In front of the desk are four orange circles representing an audience.

Education



The icon features a laptop displaying a blue and red medical record interface with a white cross symbol. Above the laptop is a stylized human hand with colorful arrows pointing downwards towards the screen.

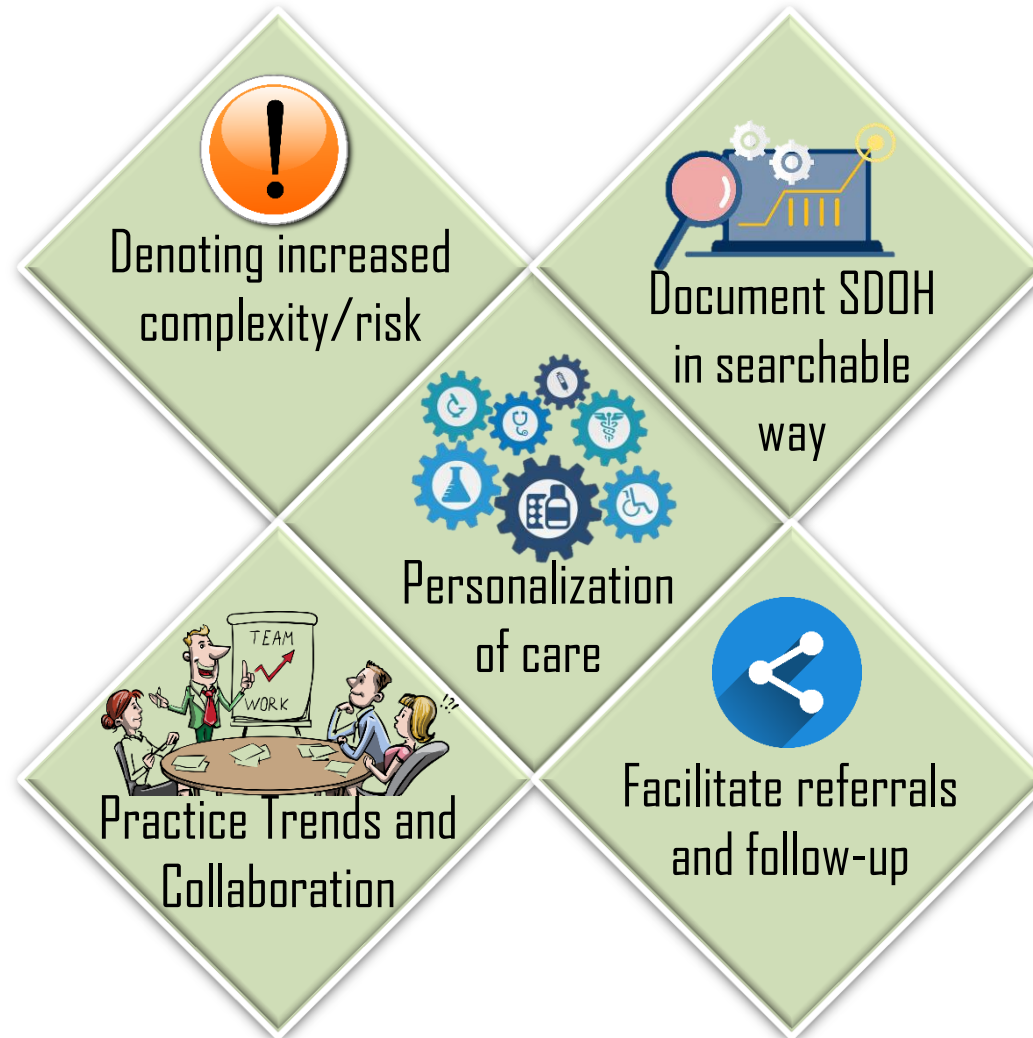
Improved Data Integration



Common SDOH Z Codes



Z Codes may help with



Vignette (borrowed from AAP)

A new patient is brought in by the mother with complaints of poor oral intake and poor weight gain. In the course of the conversation with the mother you uncover significant social issues that may be contributing to the problem. So your coding for this visit may be:

R63.6 Underweight

R62.51 Failure to thrive

Z68.51 BMI pediatric, <5th percentile for age

Z59.4 Lack of adequate food and safe drinking water

*<https://www.aappublications.org/news/2021/01/01/coding010121>



References

1. James K. Cunningham, Teshia A. Solomon, Myra L. Muramoto, Alcohol use among Native Americans compared to whites: Examining the veracity of the 'Native American elevated alcohol consumption' belief, Drug and Alcohol Dependence, Volume 160,2016,Pages 65-75,ISSN 0376-8716,<https://doi.org/10.1016/j.drugalcdep.2015.12.015>.
2. <https://www.cms.gov/files/document/cms-omh-january2020-zcode-data-highlightpdf.pdf>
3. <https://www.kff.org/coronavirus-covid-19/poll-finding/kff-covid-19-vaccine-monitor-what-weve-learned-april-2021/>
4. <https://www.reuters.com/article/us-health-coronavirus-vaccine-hesitancy/covid-19-vaccine-hesitancy-among-black-americans-drops-poll-idUSKBN2BM0WY>
5. <https://www.baltimoresun.com/opinion/op-ed/bs-ed-op-0413-vulnerable-vaccination-20210412-oe6bfhocjvbmvey4zgjuyeueme-story.html>



Poll

What do you perceive as the biggest benefit of collecting social determinants of health data for your client population?

- a) Address the underlying causes of poor health
- b) Improved care management for my patients
- c) More personalized care for my patients
- d) Higher quality of care
- e) Improved patient outcomes
- f) Cost savings

SOCIAL INTERVENTIONS

HEALTH IT

- JACOB REIDER MD
- @JACOBR

INFORMATION TECHNOLOGY

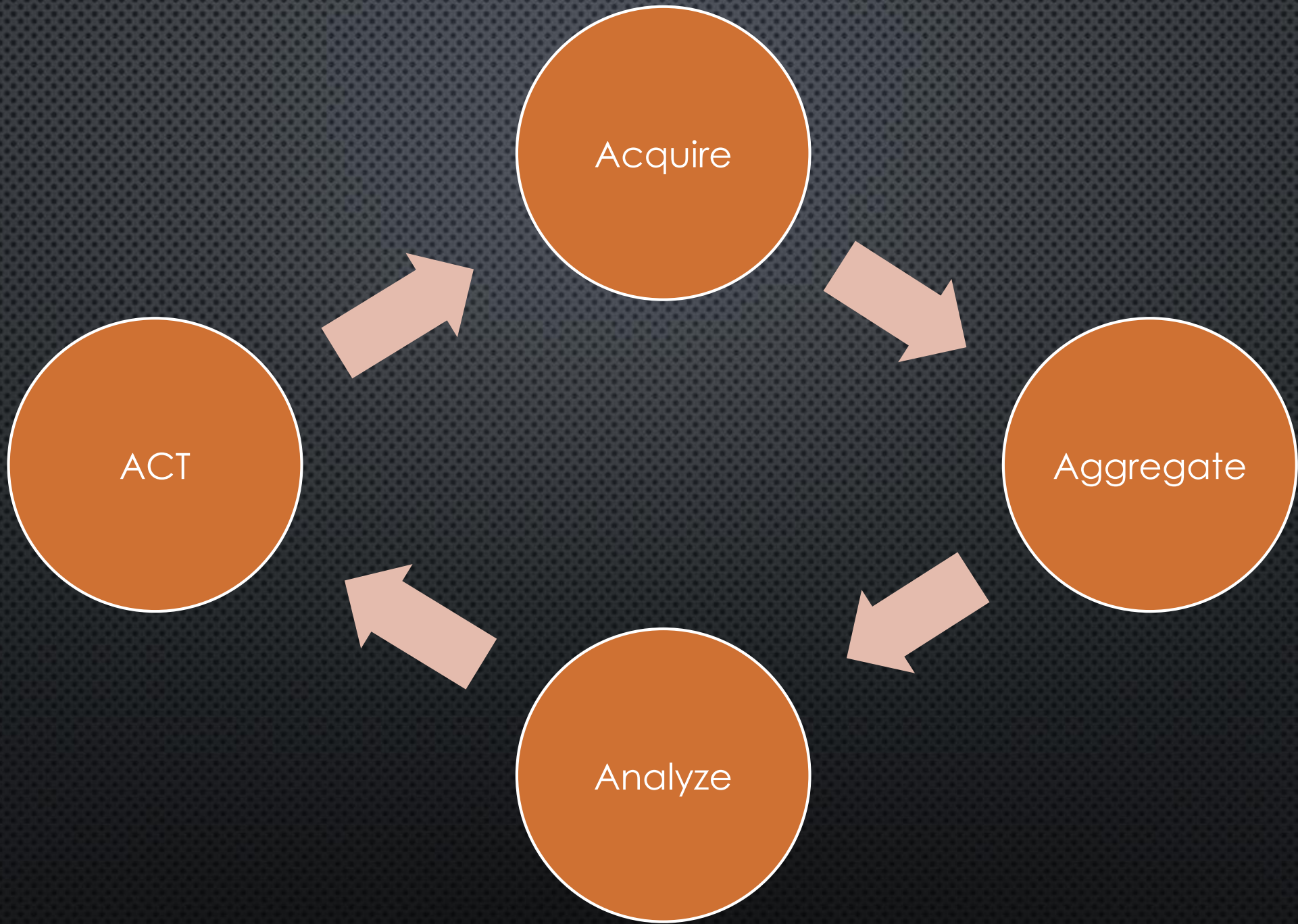


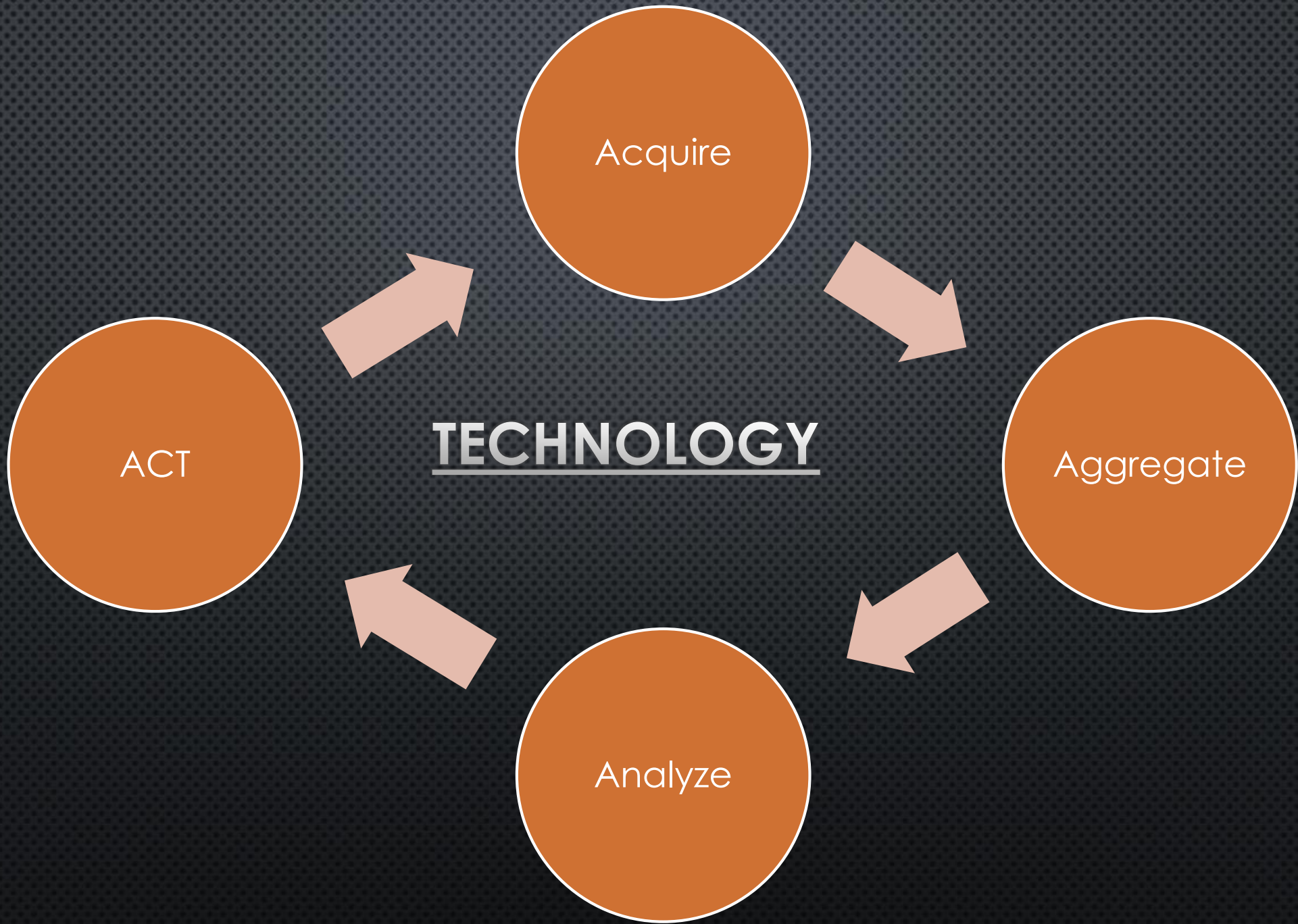
DO SOCIAL INTERVENTIONS WORK?

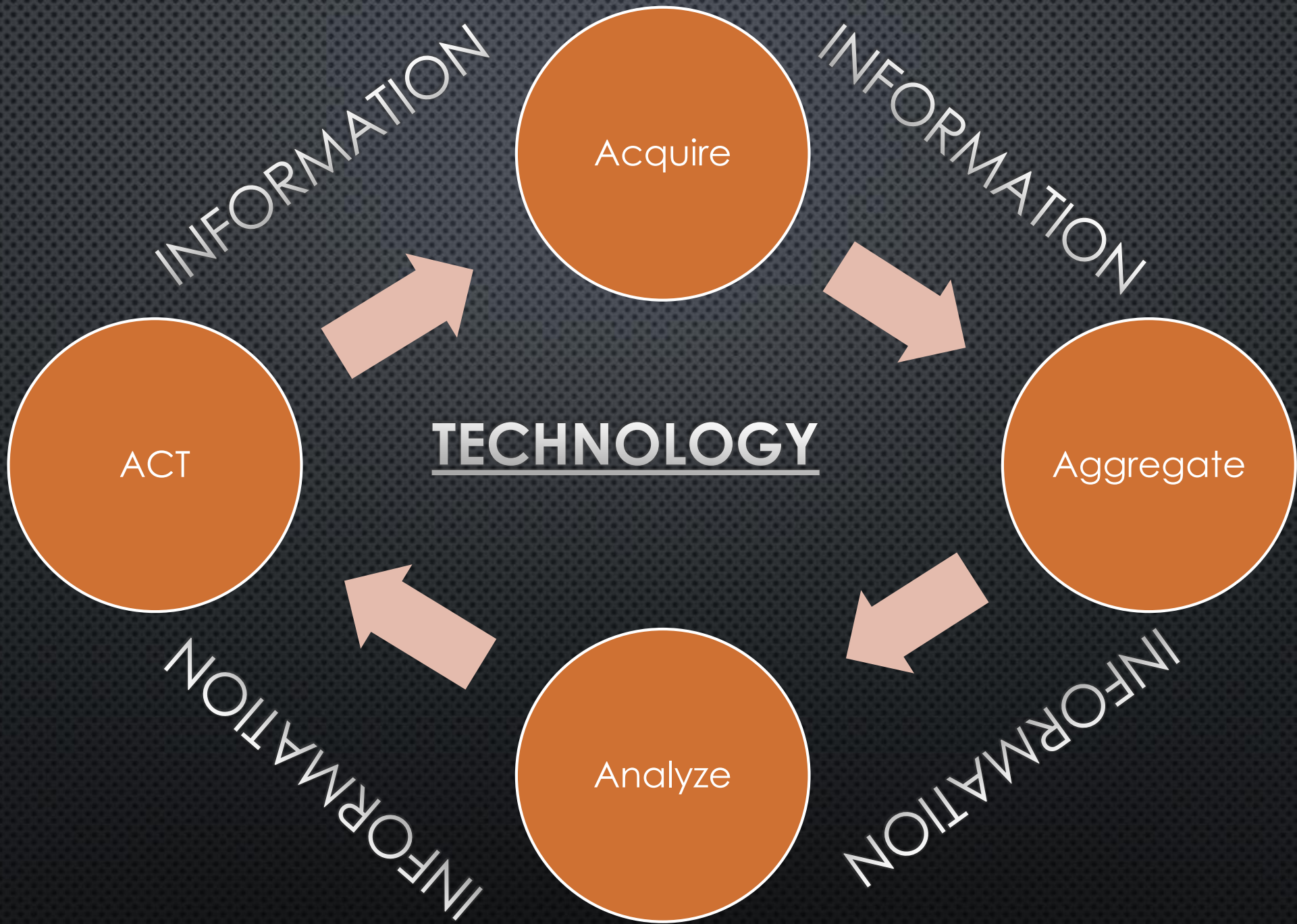
INFORMATION

TECHNOLOGY









3 Domains



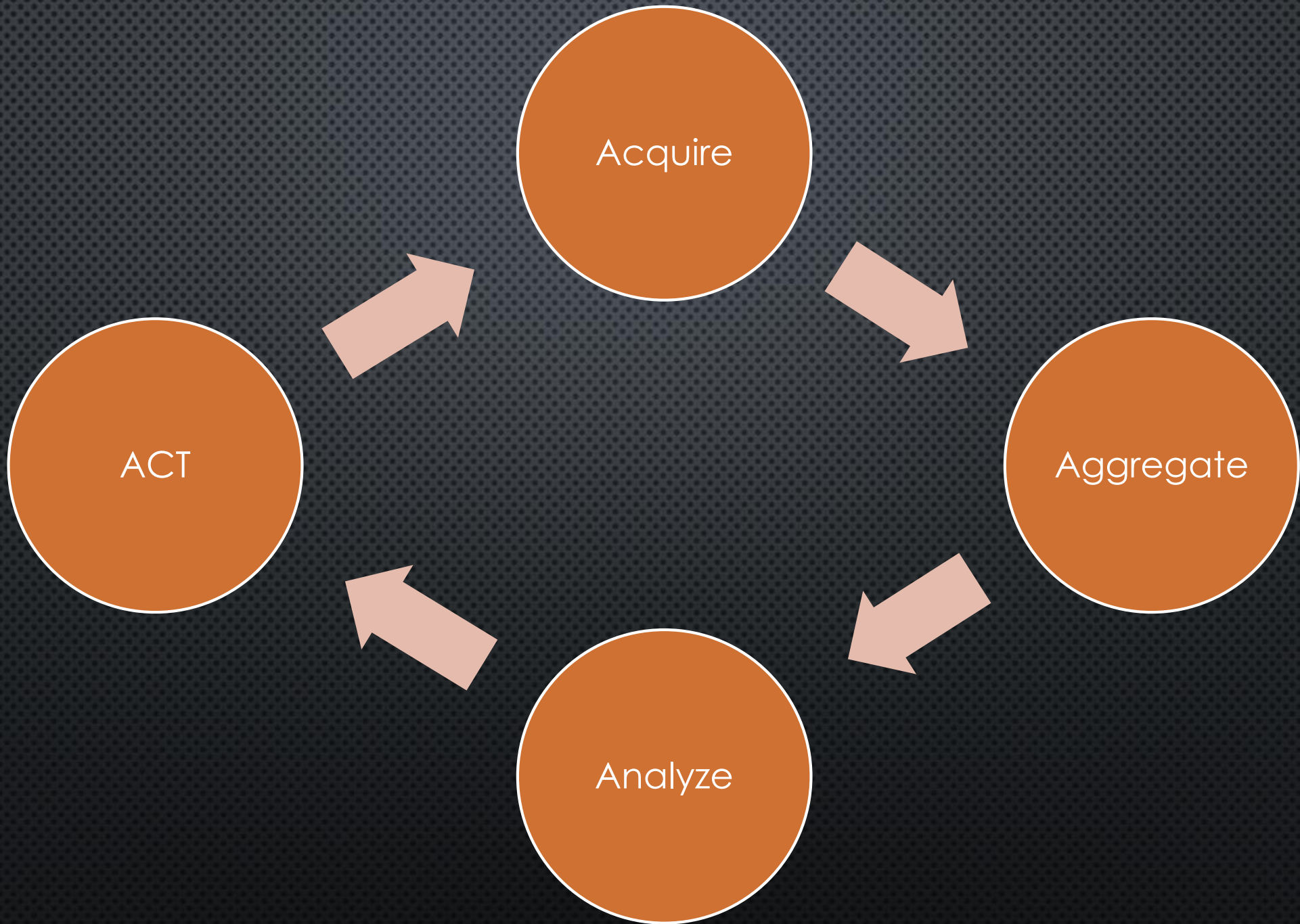
Social Care



Behavioral Health Care



Medical Care



SOCIAL NEEDS



Identify



Understand



Act



Act

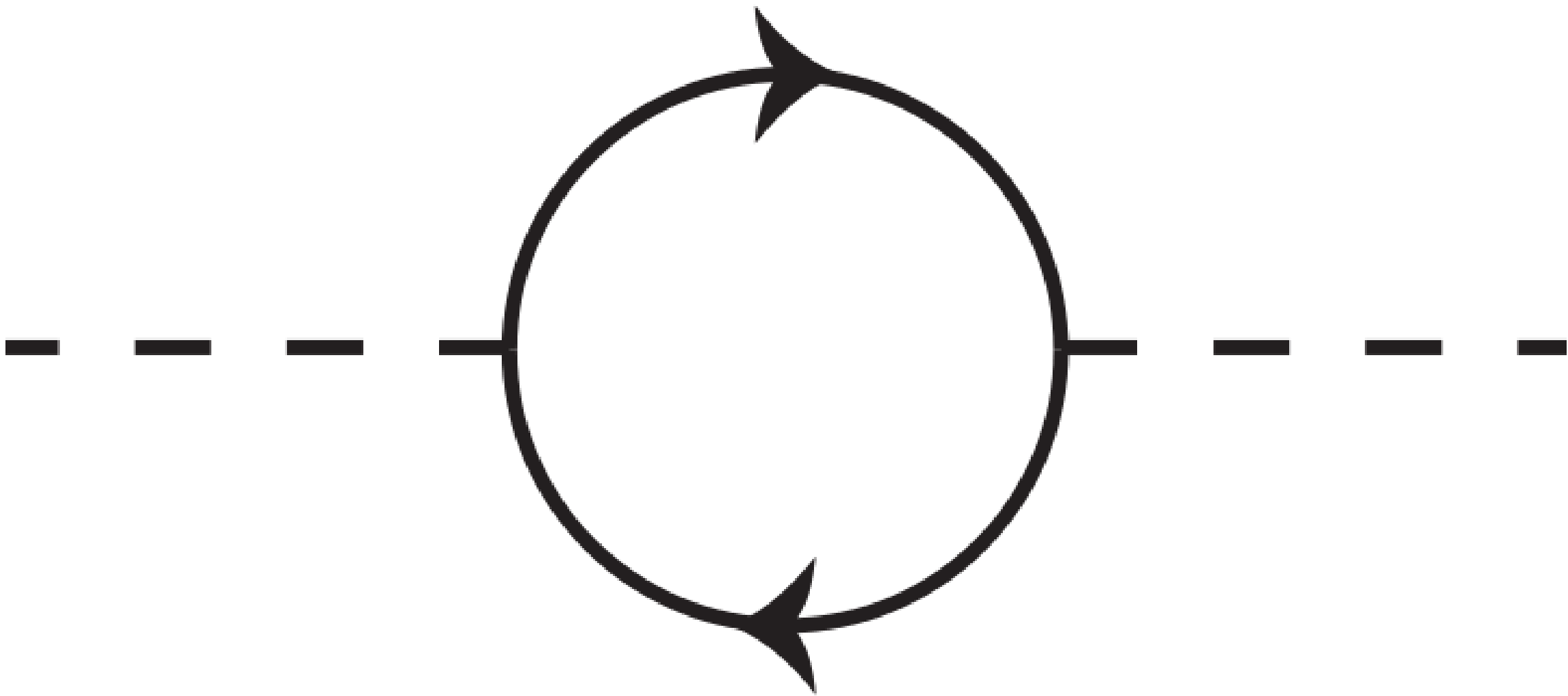


COMMUNICATE



CONFIRM





TECHNOLOGY

Screening



0



1



I Send A Message

2



3

GETTING TECHNICAL

Interoperability Standards Advisory (ISA)

The Interoperability Standards Advisory (ISA) process represents the model by which the Office of the National Coordinator for Health Information Technology (ONC) will coordinate the identification, assessment, and determination of "recognized" interoperability standards and implementation specifications for industry use to fulfill specific clinical health IT interoperability needs.



LOINC - observations and, where appropriate, the results of the observations (e.g., laboratory tests, vital signs; and for SDOH, housing instability).

SNOMED-CT - medical conditions and interventions and is used primarily for health concerns, problems and diagnoses (e.g., diabetes, COPD), and services and procedures (e.g., hip replacement, immunization)

ICD-10-CM - administrative equivalent of health concerns, problems and diagnoses when communicating with a healthcare insurer.

CPT and HCPCS - services and procedures when communicating with a health plan.

RXnorm - medication and/or allergy to a medication.



Introducing the Gravity Project

We are a national public collaborative that develops consensus-based data standards to improve how we use and share information on social determinants of health (SDOH).

PRODUCTS

- SCREENING
- DIRECTORY
- REFERRAL
- FOLLOW-UP



Healthify



aunt
bertha



UNITE US

NEW POW

CONNIE



Fade to Connie | MATCH
matchhouston.org



Connie Maheswaran | L...
loveinterest.fandom.com



Connie Talbot - Wikip...
en.wikipedia.org



Connie Nielsen - Wikip...
en.wikipedia.org



Connie Chung discusses her cameo i...
cnn.com



Connie Nielsen Shares Harvey Weins...
variety.com



Q&A: 'Nashville' Actress Connie Britton...
rollingstone.com



Emmy® Award-Nomina...
prnewswire.com



Country Music | Connie Smith Biography ...
pbs.org

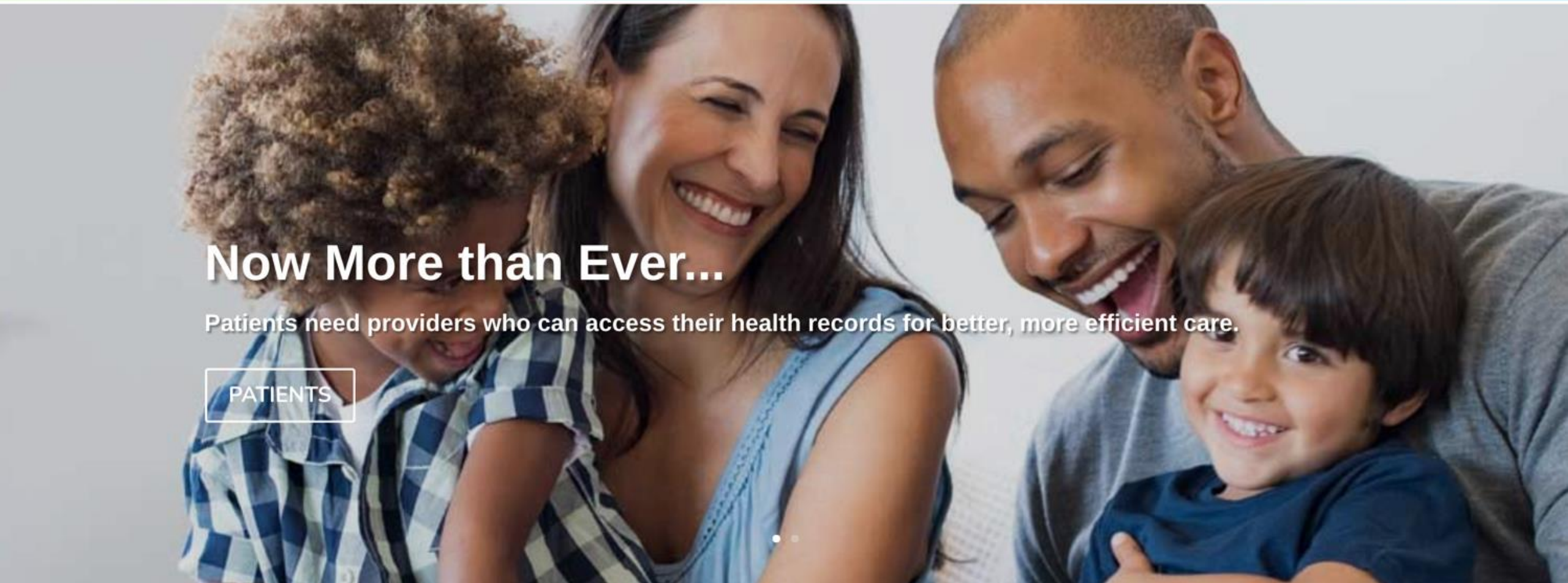


Connie Britton on How She Made Her ...
vulture.com



Connie Francis Earns Lifetime ...
people.com



A photograph of a diverse family of four smiling together. A woman with long dark hair is in the center, smiling broadly. To her left is a young boy with curly hair, and to her right is a man with a beard, also smiling. In the foreground on the right is a young girl with dark hair, smiling. The background is a plain, light-colored wall.

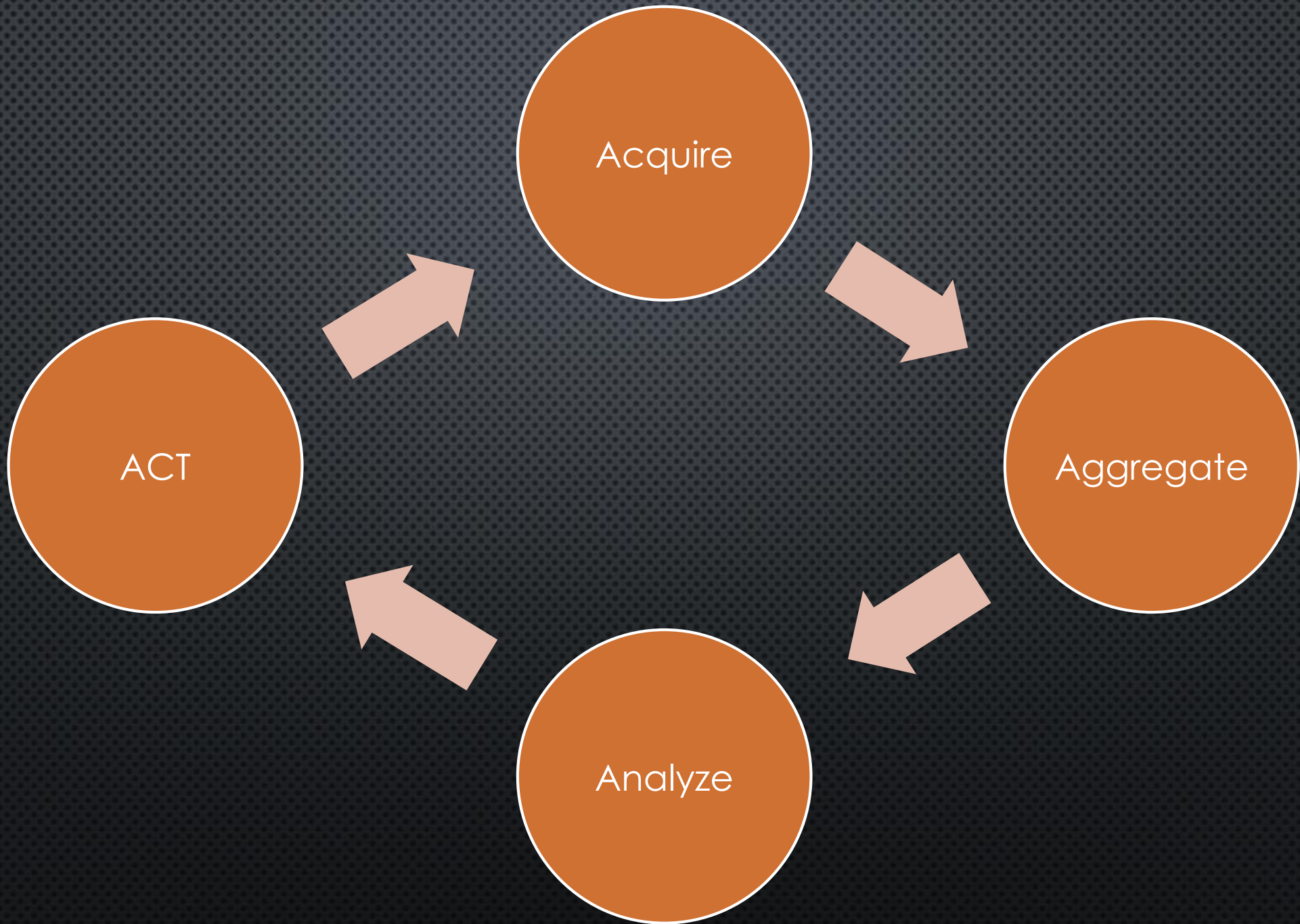
Now More than Ever...

Patients need providers who can access their health records for better, more efficient care.

PATIENTS



1



Solution
Probleme



RIGHT THING



EASY THING

DO SOCIAL INTERVENTIONS WORK?



Poll

What is the biggest barriers you experience in collecting and/or using social determinants of health data?

- a) Perceived lack of payment for SDOH
- b) Staff expertise and capacity
- c) Implicit bias and cultural proficiency
- d) Lack of resources in patients' communities
- e) Ensuring that patients know what to do and how to follow up with you
- f) Engaging the health care team and building momentum

Questions

- Contact us with any comments /
HIELearning@uchc.edu
Or
- Visit us at:
<https://health.uconn.edu/health-interopability-learning/>

Stay tuned for the next event!