Caring for the Whole Patient:

Using Health IT to Address Social Determinants of Health

ACPE UAN: 0009-9999-21-018-L04-P

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This webinar is funded by grants from:

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

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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

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Health Information Technology for Clinicians:
How to Achieve Optimal Outcomes

Sample Topics

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

This series is funded by a grant from the Connecticut Office of Health Strategy, which did not influence the content of the program.

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Housekeeping

All participant lines will be muted during the panel discussion

The panelist will address you 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.

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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

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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

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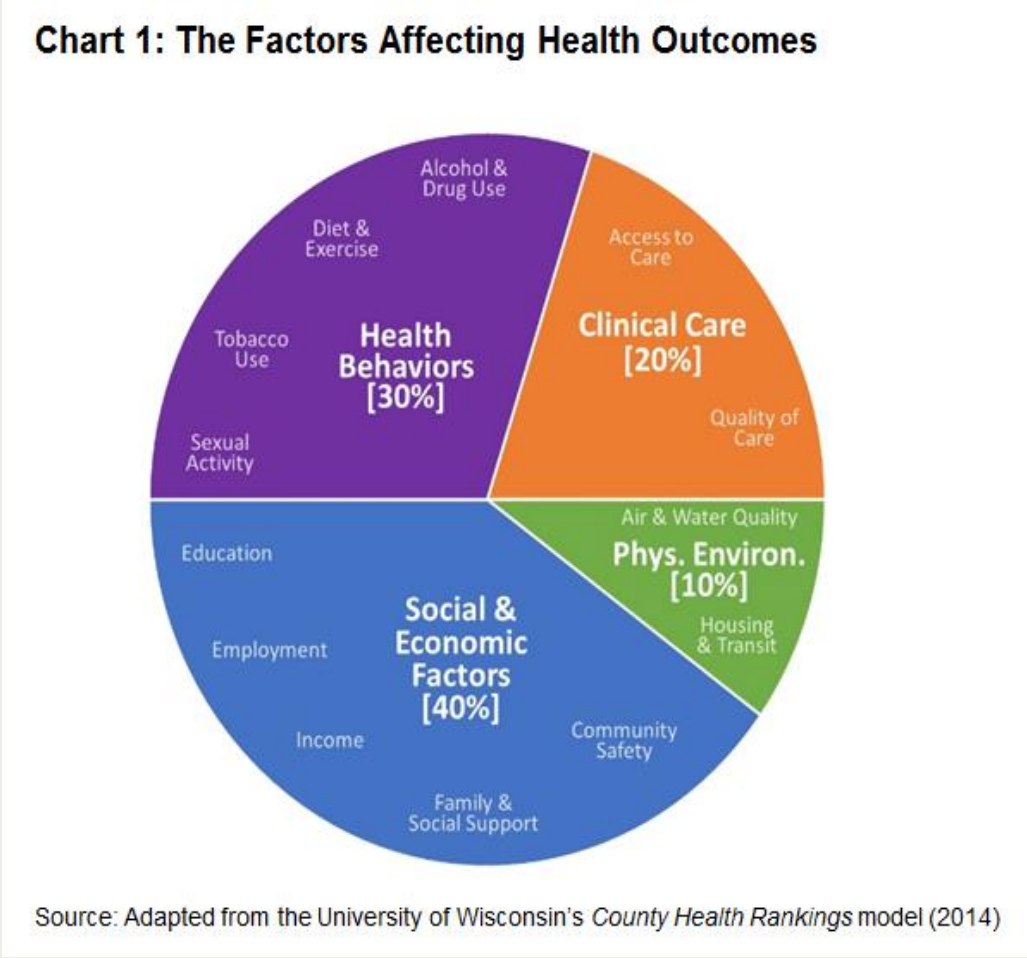
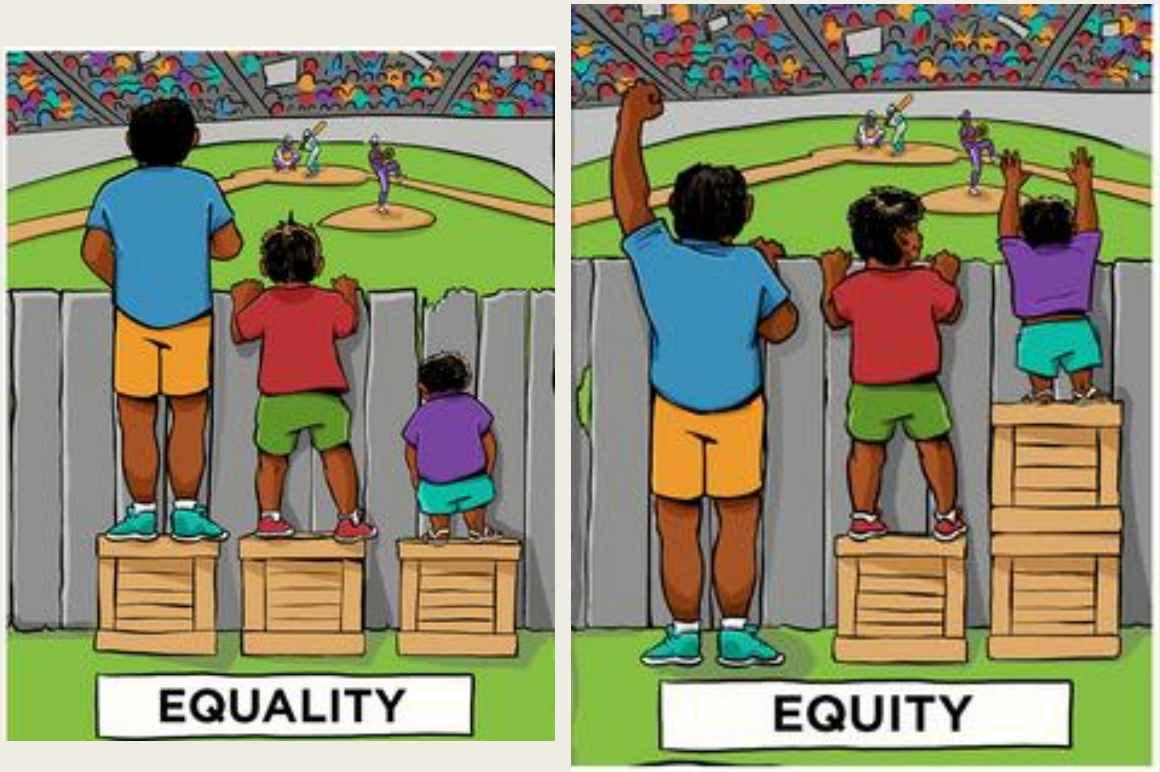
DEFINITIONS

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



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.

Images adapted from Story Based Strategy
http://www.storybasedstrategy.org/blog/the4thbox

SOCIAL DETERMINANTS OF HEALTH

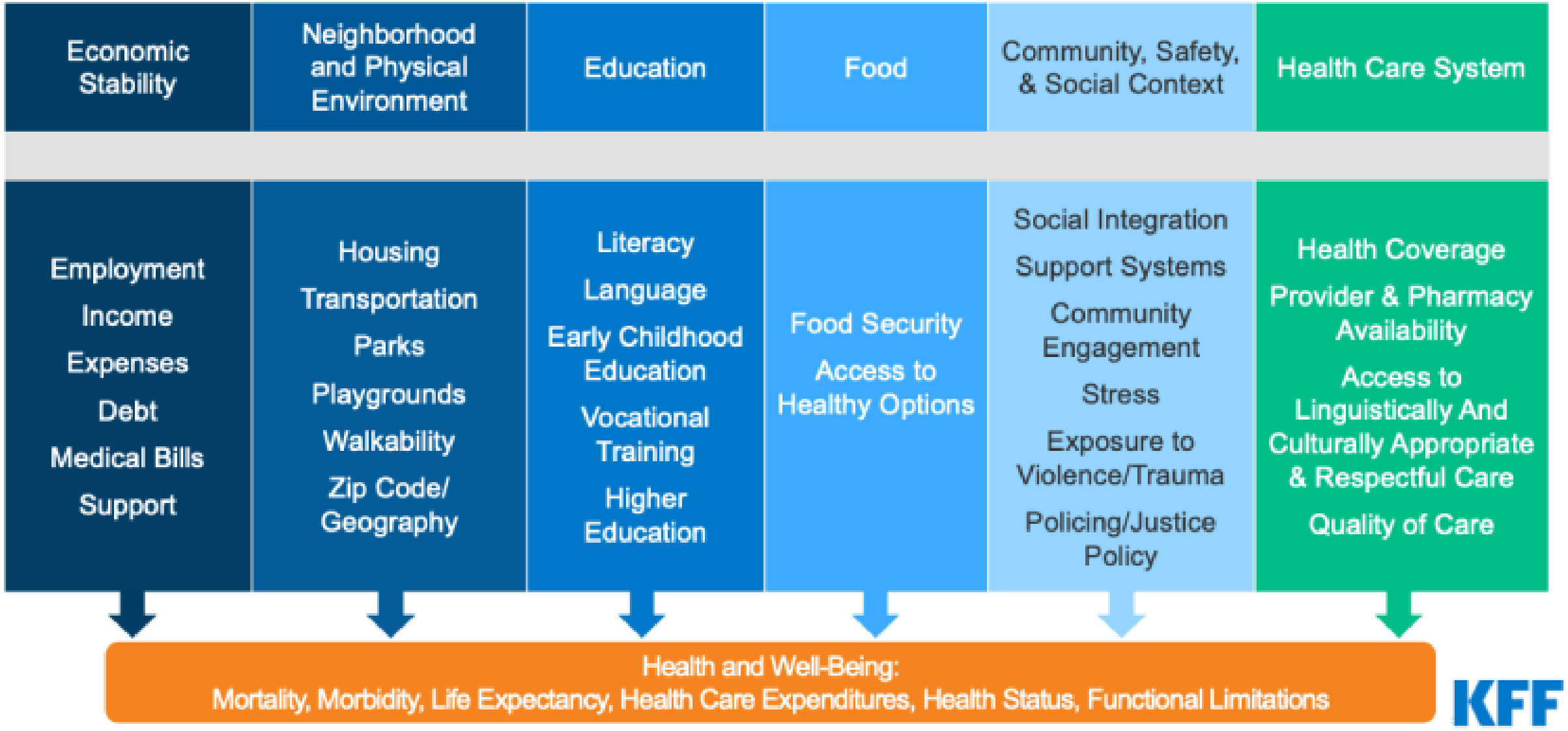
Social Determinants of Health

"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

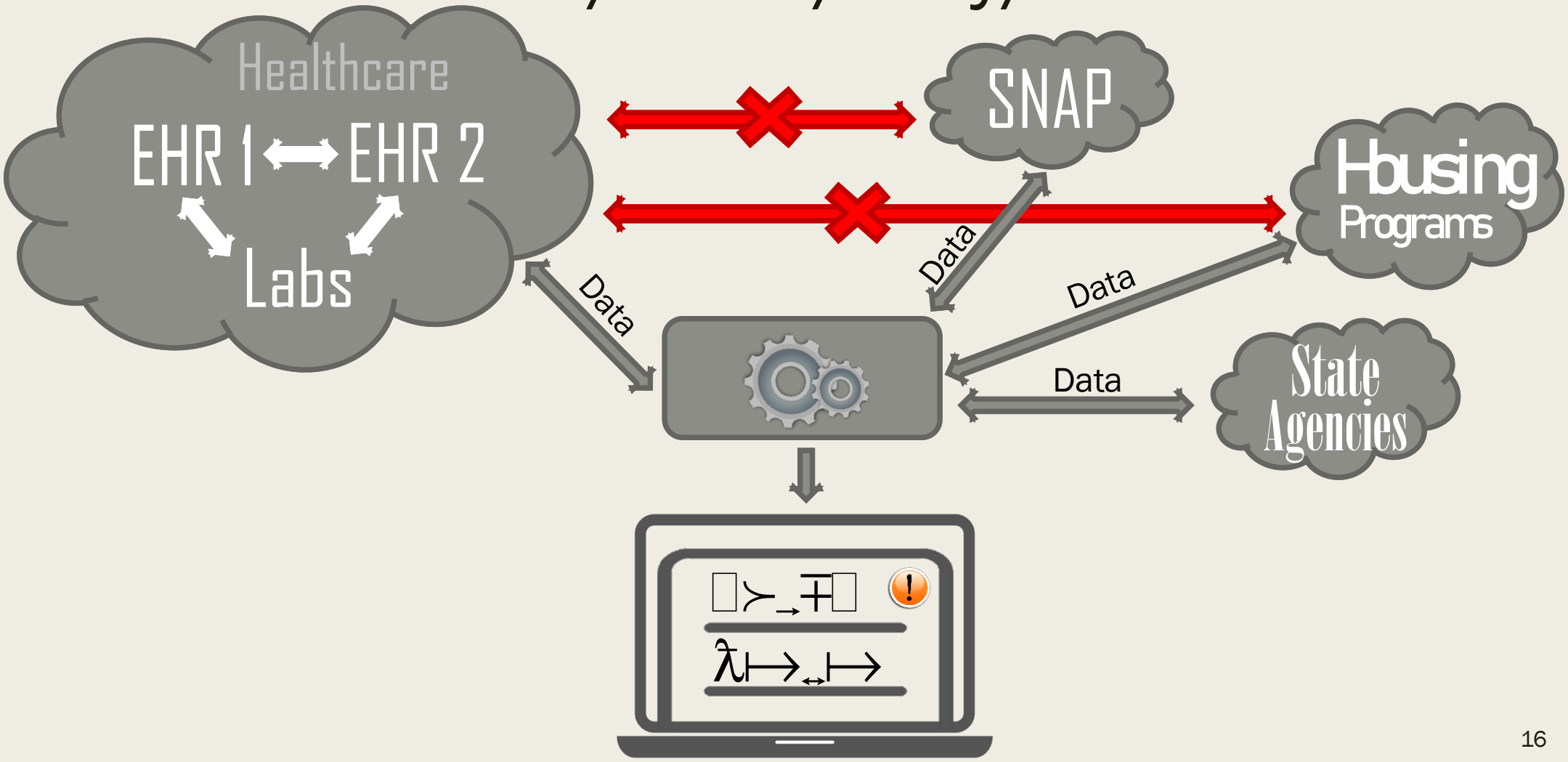
Social Determinants of Health



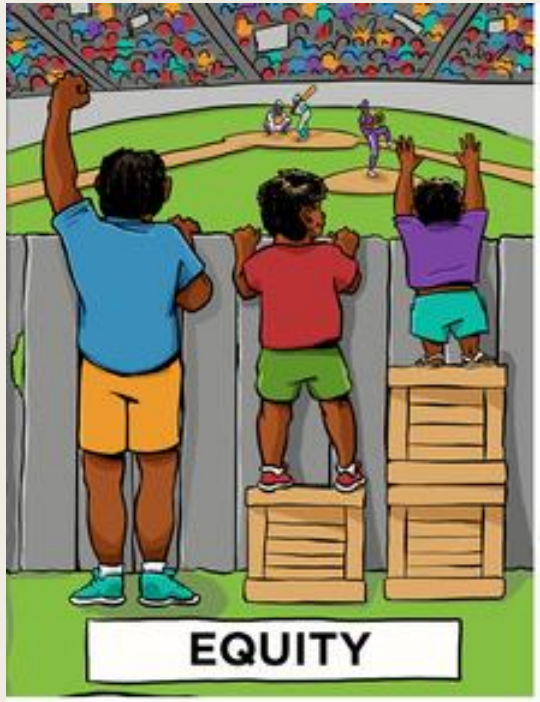
Why is this Important?

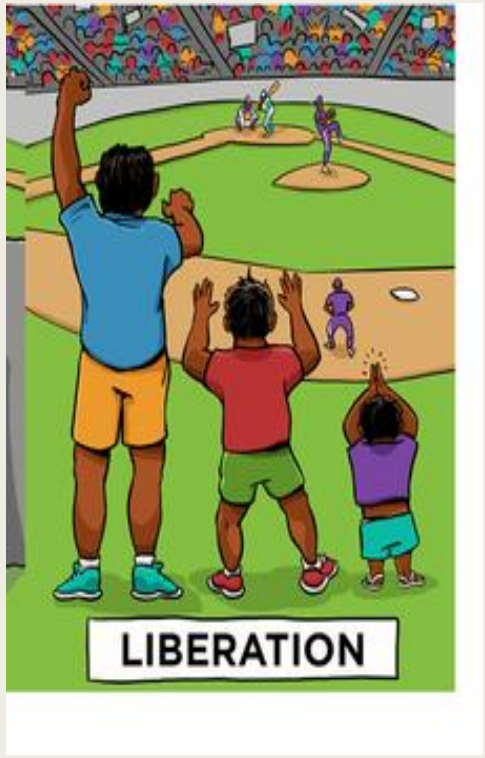
- The factors that make up our individual and community health impact *all* of us, *all* the time
- While it impacts everyone, we're not all impacted in the same way
- These determinants do not happen by accident

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

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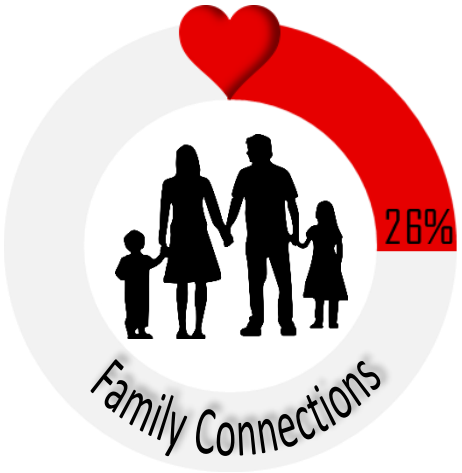
“Social Determinants of Health”



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Social Determinants of Health

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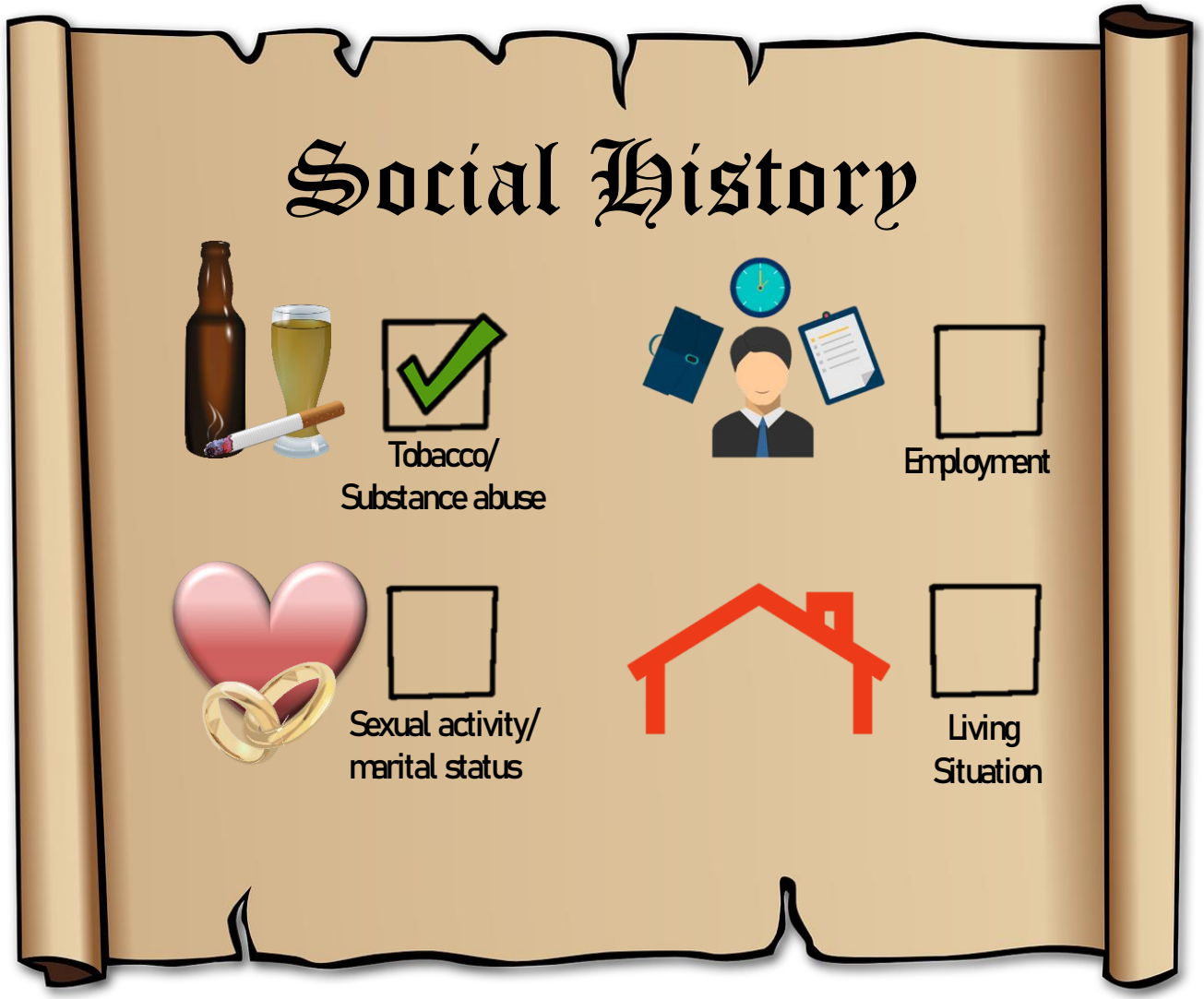
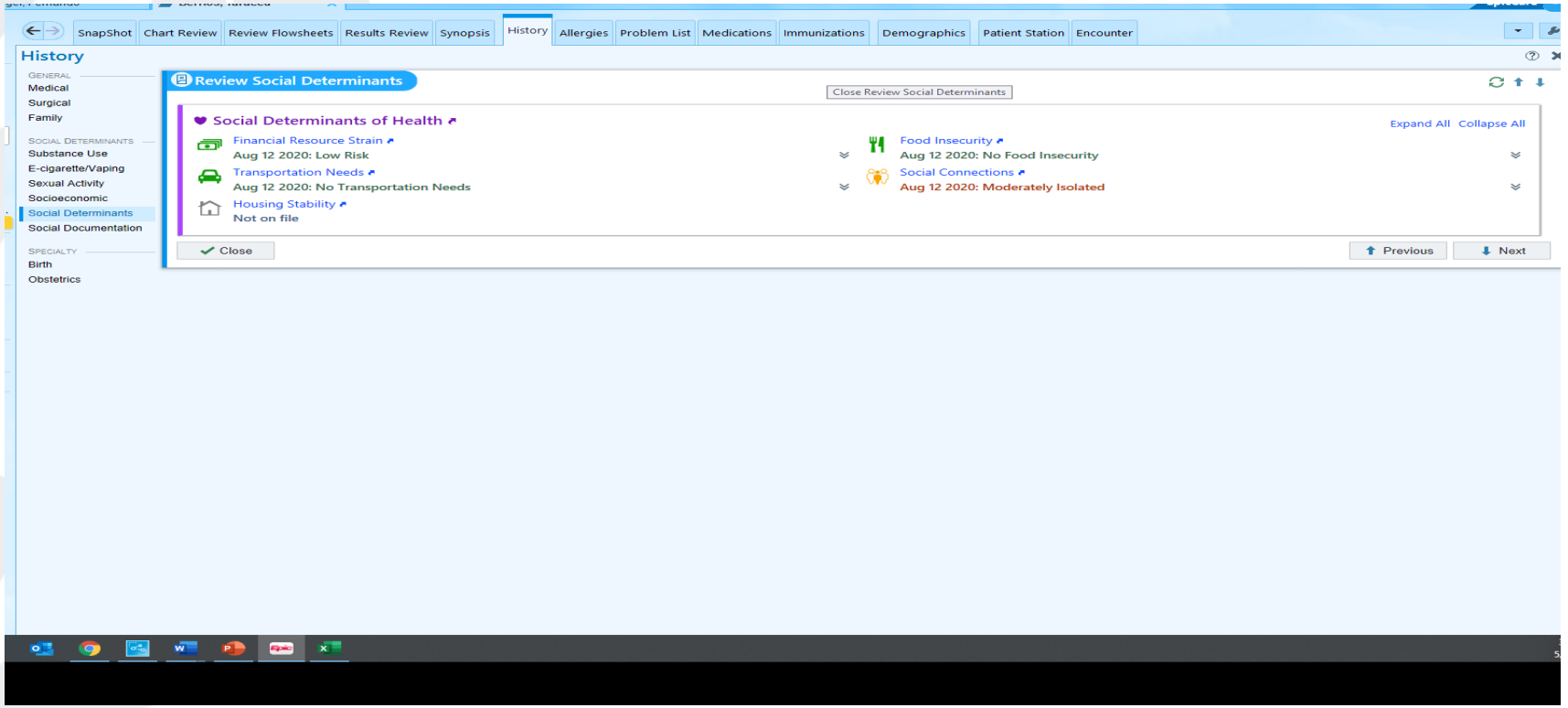
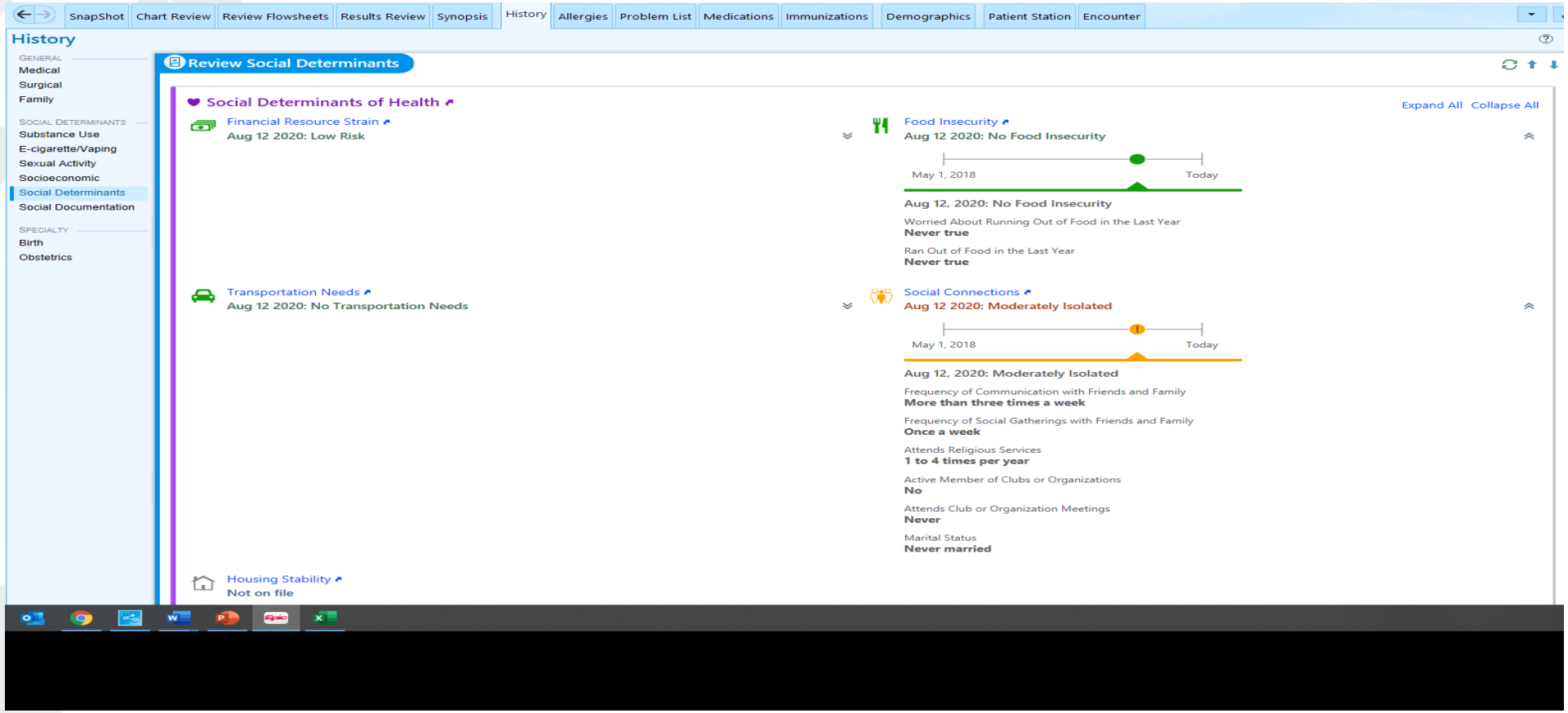
Previous Medical School Teachings



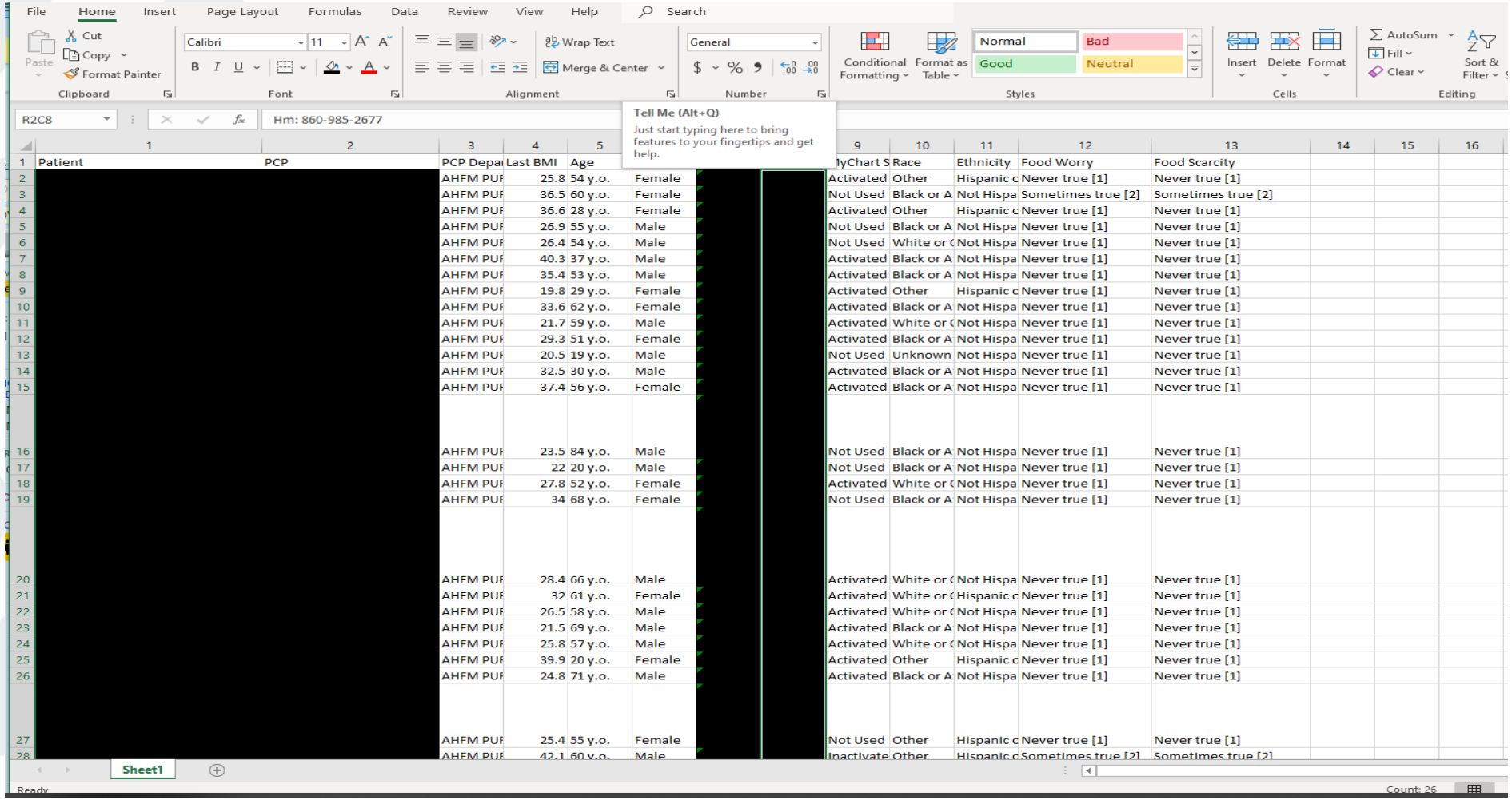
Social Determinants of Health in Health Care Delivery



Social Determinants of Health in Health Care Delivery



Food Insecurity Report



Patient	PCP	PCP Depa	Last BMI	Age		MyChart S	Race	Ethnicity	Food Worry	Food Scarcity
[redacted]	[redacted]	AHFM PUF	25.8	54 y.o.	Female	[redacted]	Activated	Other	Hispanic c	Never true [1]	Never true [1]
		AHFM PUF	36.5	60 y.o.	Female		Not Used	Black or A	Not Hispa	Sometimes true [2]	Sometimes true [2]
		AHFM PUF	36.6	28 y.o.	Female		Activated	Other	Hispanic c	Never true [1]	Never true [1]
		AHFM PUF	26.9	55 y.o.	Male		Not Used	Black or A	Not Hispa	Never true [1]	Never true [1]
		AHFM PUF	26.4	54 y.o.	Male		Not Used	White or (	Not Hispa	Never true [1]	Never true [1]
		AHFM PUF	40.3	37 y.o.	Male		Activated	Black or A	Not Hispa	Never true [1]	Never true [1]
		AHFM PUF	35.4	53 y.o.	Male		Activated	Black or A	Not Hispa	Never true [1]	Never true [1]
		AHFM PUF	19.8	29 y.o.	Female		Activated	Other	Hispanic c	Never true [1]	Never true [1]
		AHFM PUF	33.6	62 y.o.	Female		Activated	Black or A	Not Hispa	Never true [1]	Never true [1]
		AHFM PUF	21.7	59 y.o.	Male		Activated	White or (	Not Hispa	Never true [1]	Never true [1]
		AHFM PUF	29.3	51 y.o.	Female		Activated	Black or A	Not Hispa	Never true [1]	Never true [1]
		AHFM PUF	20.5	19 y.o.	Male		Not Used	Unknown	Not Hispa	Never true [1]	Never true [1]
		AHFM PUF	32.5	30 y.o.	Male		Activated	Black or A	Not Hispa	Never true [1]	Never true [1]
		AHFM PUF	37.4	56 y.o.	Female		Activated	Black or A	Not Hispa	Never true [1]	Never true [1]
		AHFM PUF	23.5	84 y.o.	Male		Not Used	Black or A	Not Hispa	Never true [1]	Never true [1]
		AHFM PUF	22	20 y.o.	Male		Not Used	Black or A	Not Hispa	Never true [1]	Never true [1]
		AHFM PUF	27.8	52 y.o.	Female		Activated	White or (	Not Hispa	Never true [1]	Never true [1]
		AHFM PUF	34	68 y.o.	Female		Not Used	Black or A	Not Hispa	Never true [1]	Never true [1]
		AHFM PUF	28.4	66 y.o.	Male		Activated	White or (	Not Hispa	Never true [1]	Never true [1]
		AHFM PUF	32	61 y.o.	Female		Activated	White or (	Hispanic c	Never true [1]	Never true [1]
		AHFM PUF	26.5	58 y.o.	Male		Activated	White or (	Not Hispa	Never true [1]	Never true [1]
		AHFM PUF	21.5	69 y.o.	Male		Activated	Black or A	Not Hispa	Never true [1]	Never true [1]
		AHFM PUF	25.8	57 y.o.	Male		Activated	White or (	Not Hispa	Never true [1]	Never true [1]
		AHFM PUF	39.9	20 y.o.	Female		Activated	Other	Hispanic c	Never true [1]	Never true [1]
		AHFM PUF	24.8	71 y.o.	Male		Activated	Black or A	Not Hispa	Never true [1]	Never true [1]
		AHFM PUF	25.4	55 y.o.	Female		Not Used	Other	Hispanic c	Never true [1]	Never true [1]
		AHFM PUF	42.1	60 y.o.	Male		Inactivate	Other	Hispanic c	Sometimes true [2]	Sometimes true [2]

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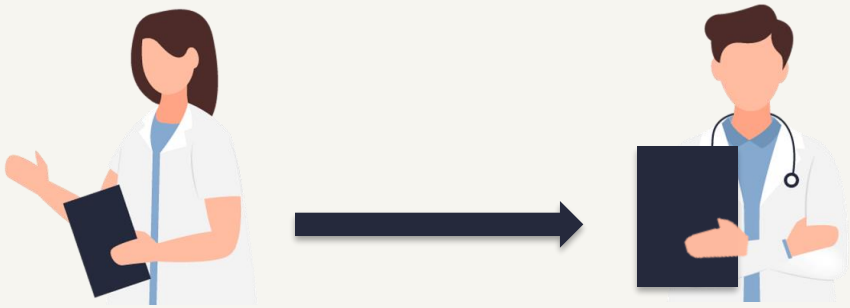
SDOH Data Collection and Use

Workflow



Data Use

Foster collaboration within interprofessional care teams

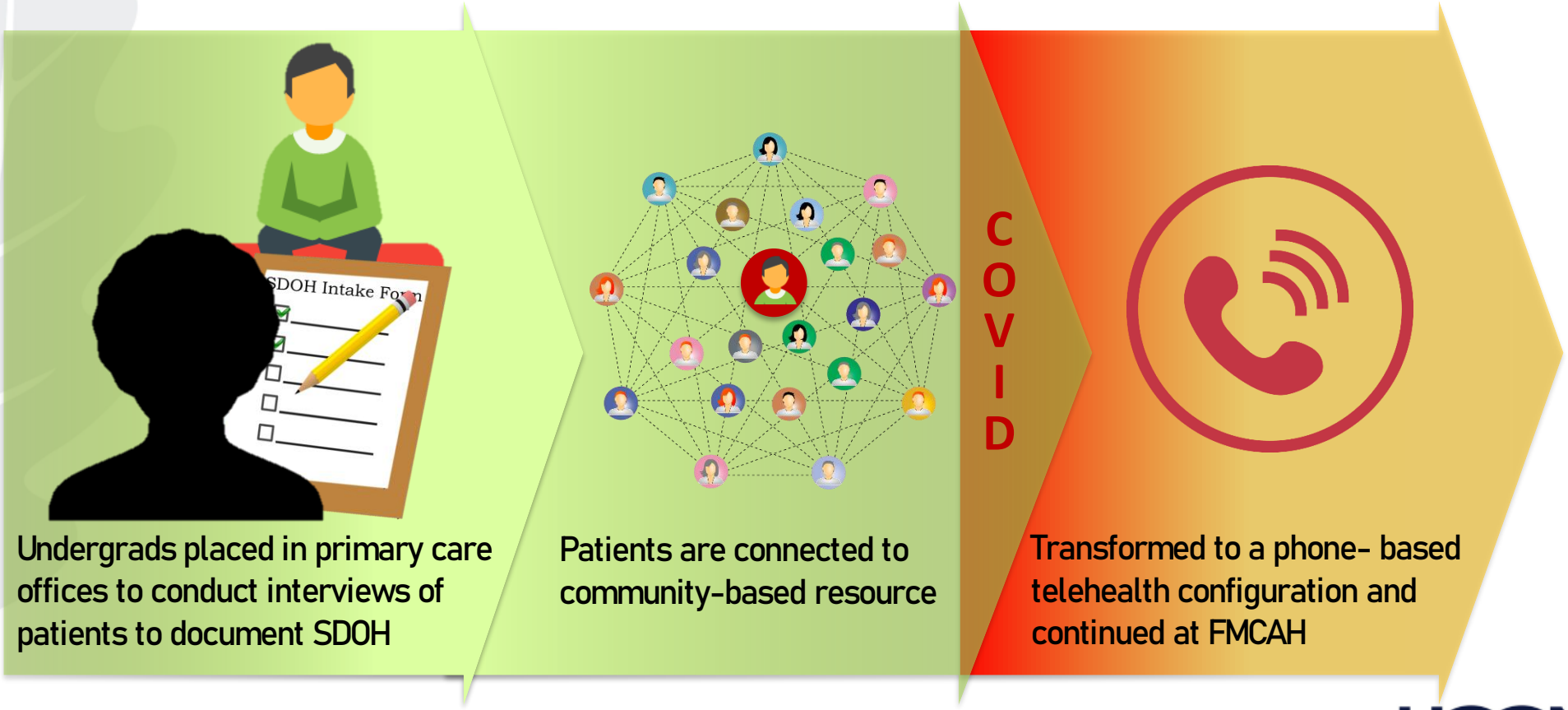
Facilitate communication related to interventions

Document progress toward resolution

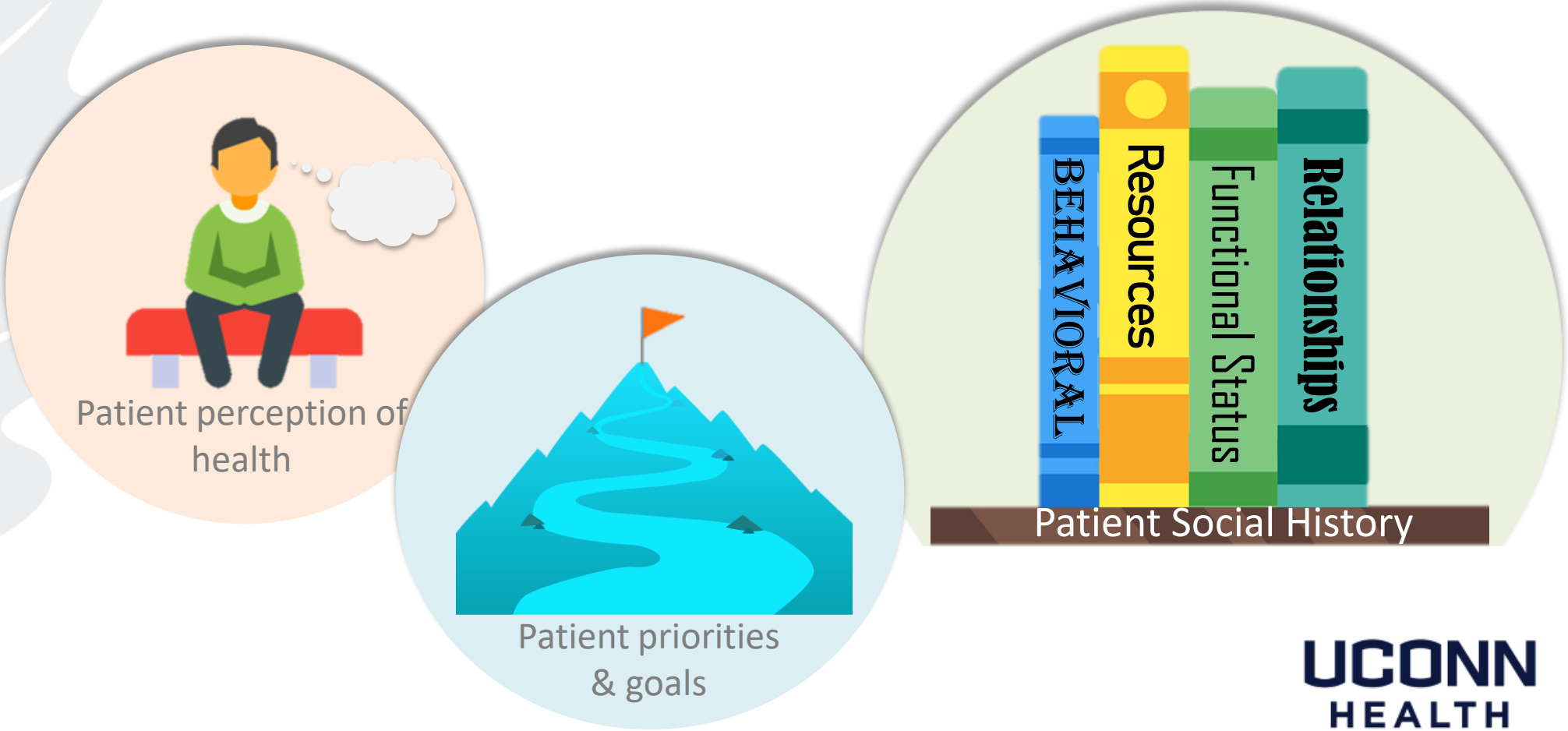
Facilitate community-based healthcare delivery

Share aggregated data with DPH and community partners

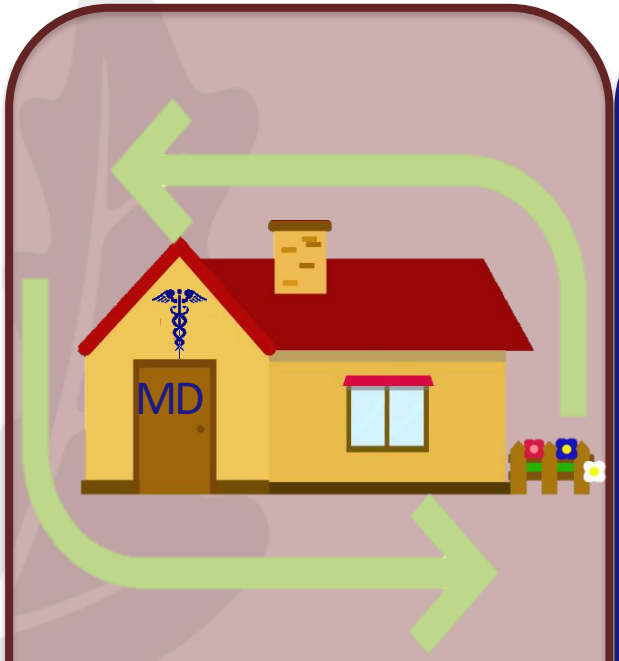
UConn Health Leaders



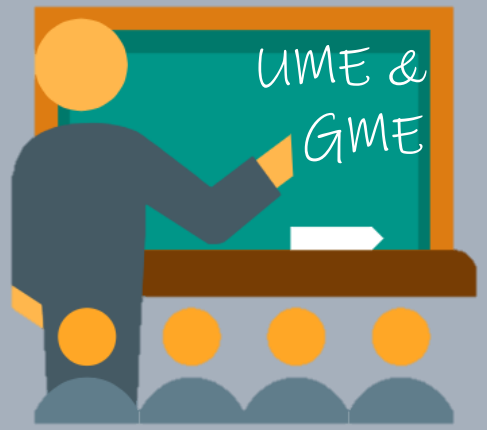
New SDOH Informed History – “360 H&P” (AMA ACE Consortium)



Opportunities and Challenges



Practice Transformation

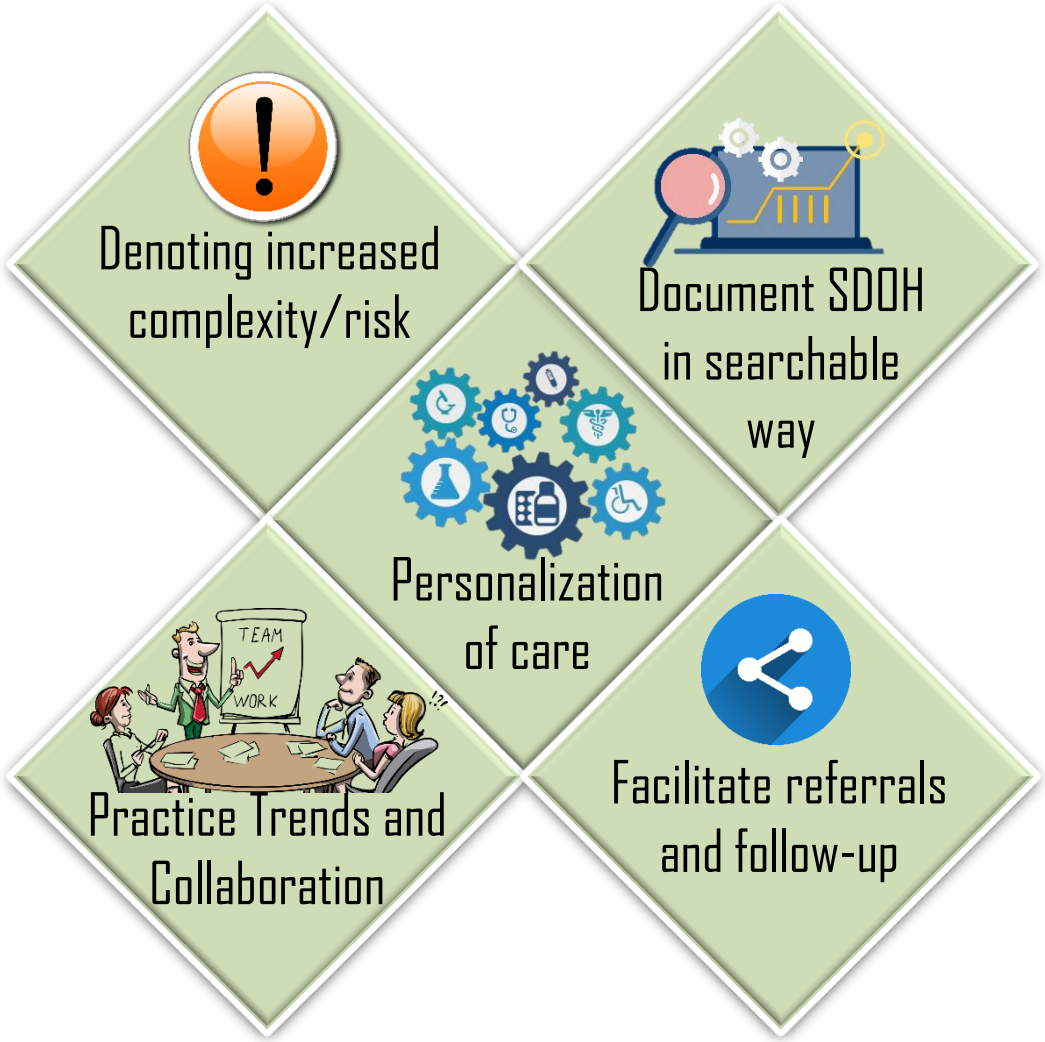


Education

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:

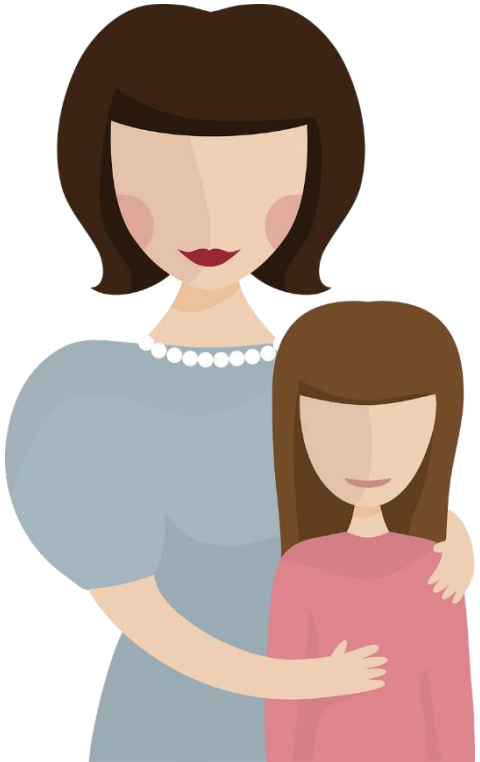
R63.6 Underweight

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



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References

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5. https://www.baltimoresun.com/opinion/op-ed/bs-ed-op-0413-vulnerable-vaccination-20210412-oe6bfhocjvbmvey4zgjuyeueme-story.html

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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

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SOCIAL INTERVENTIONS

HEALTH IT

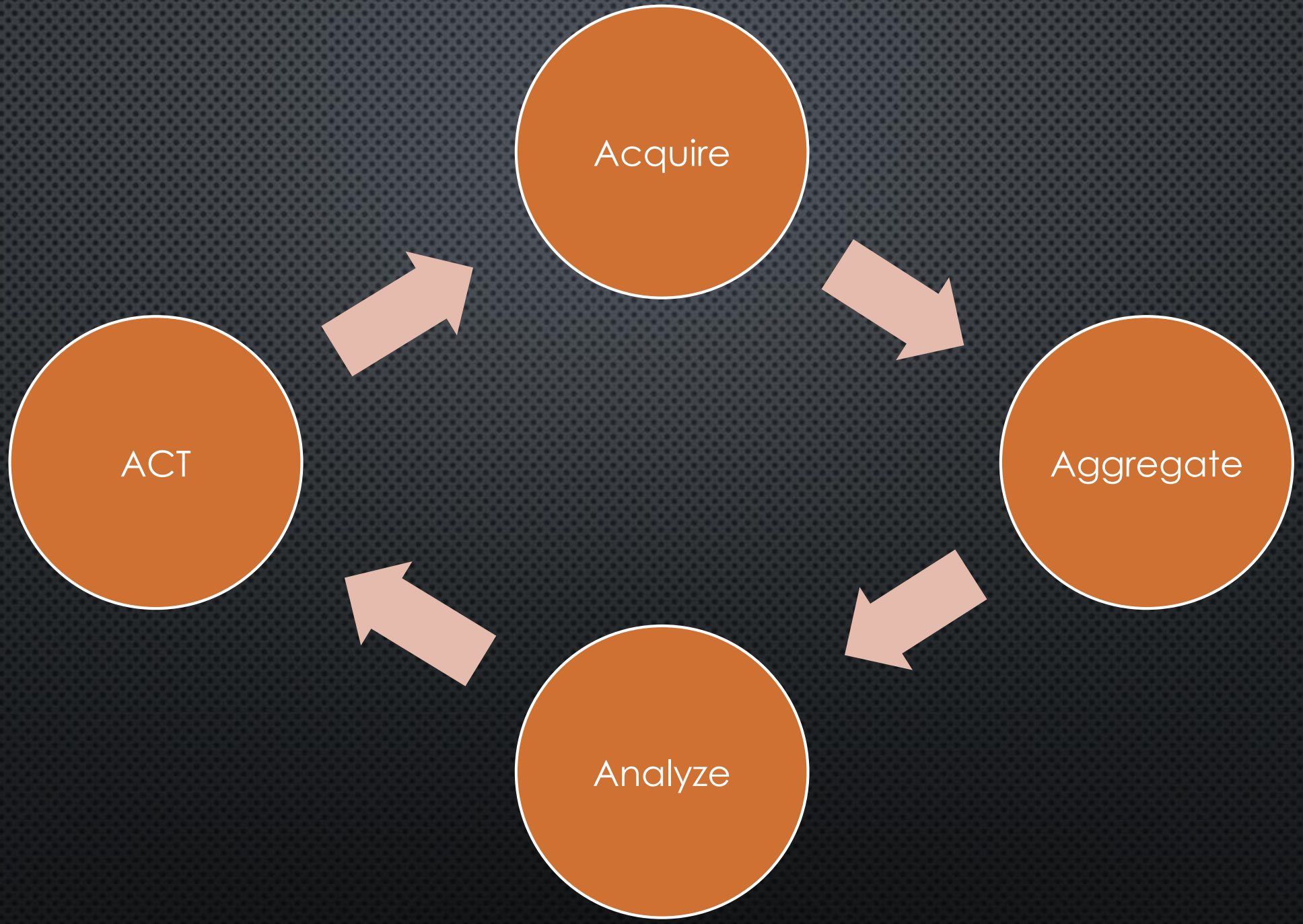
- Jacob Reider MD
- @jacobr

INFORMATION TECHNOLOGY

DO SOCIAL INTERVENTIONS WORK?

INFORMATION

TECHNOLOGY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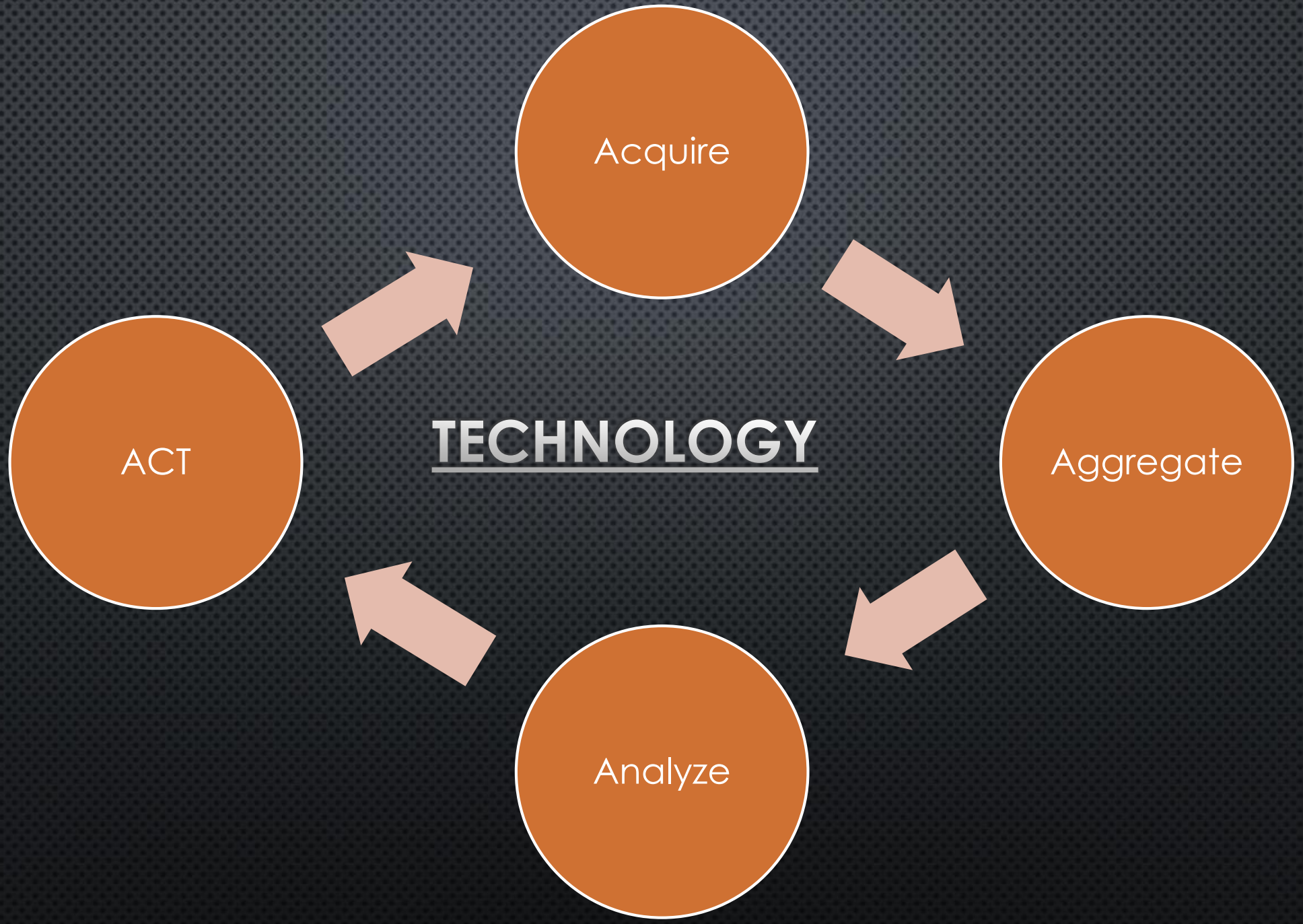
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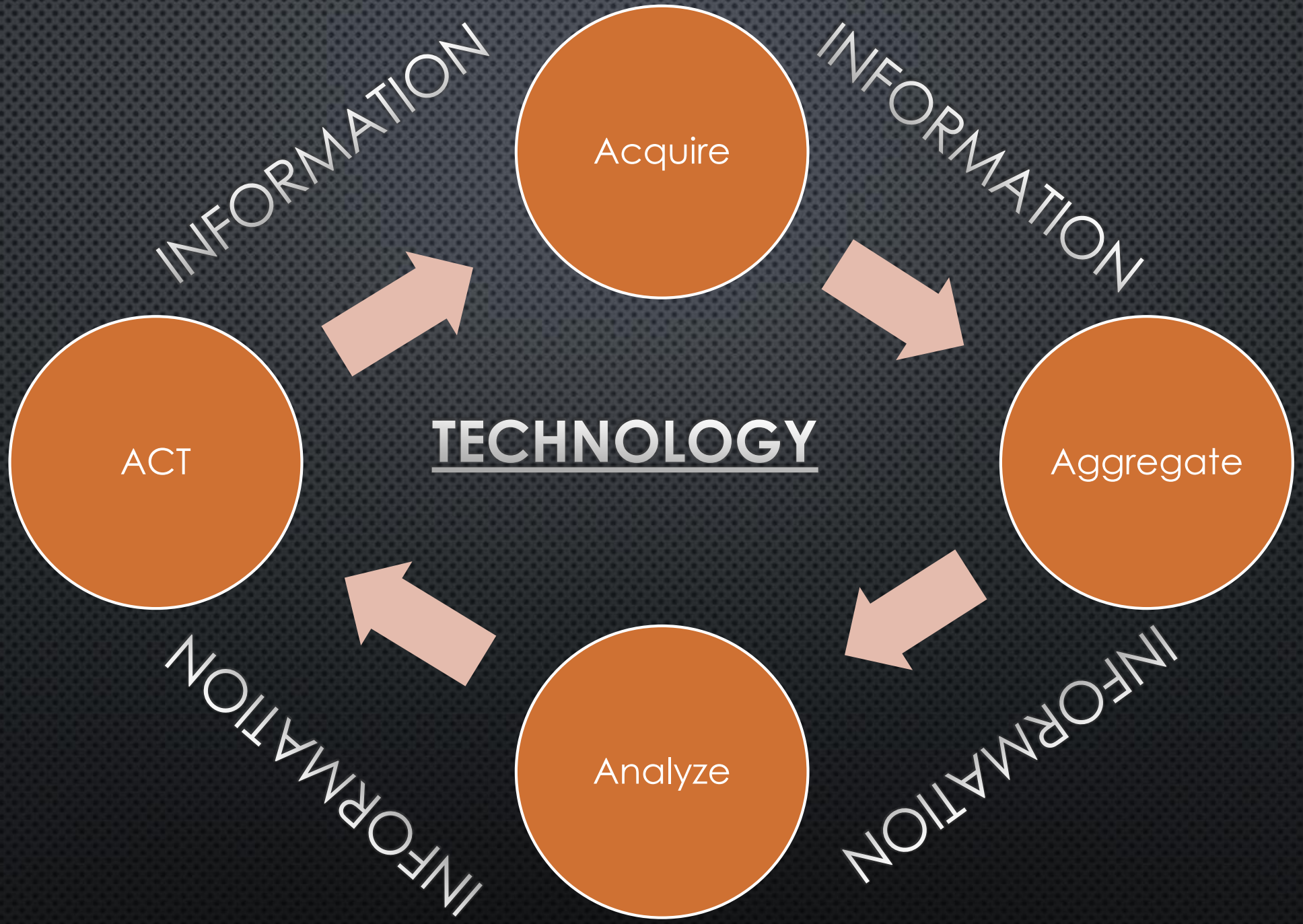
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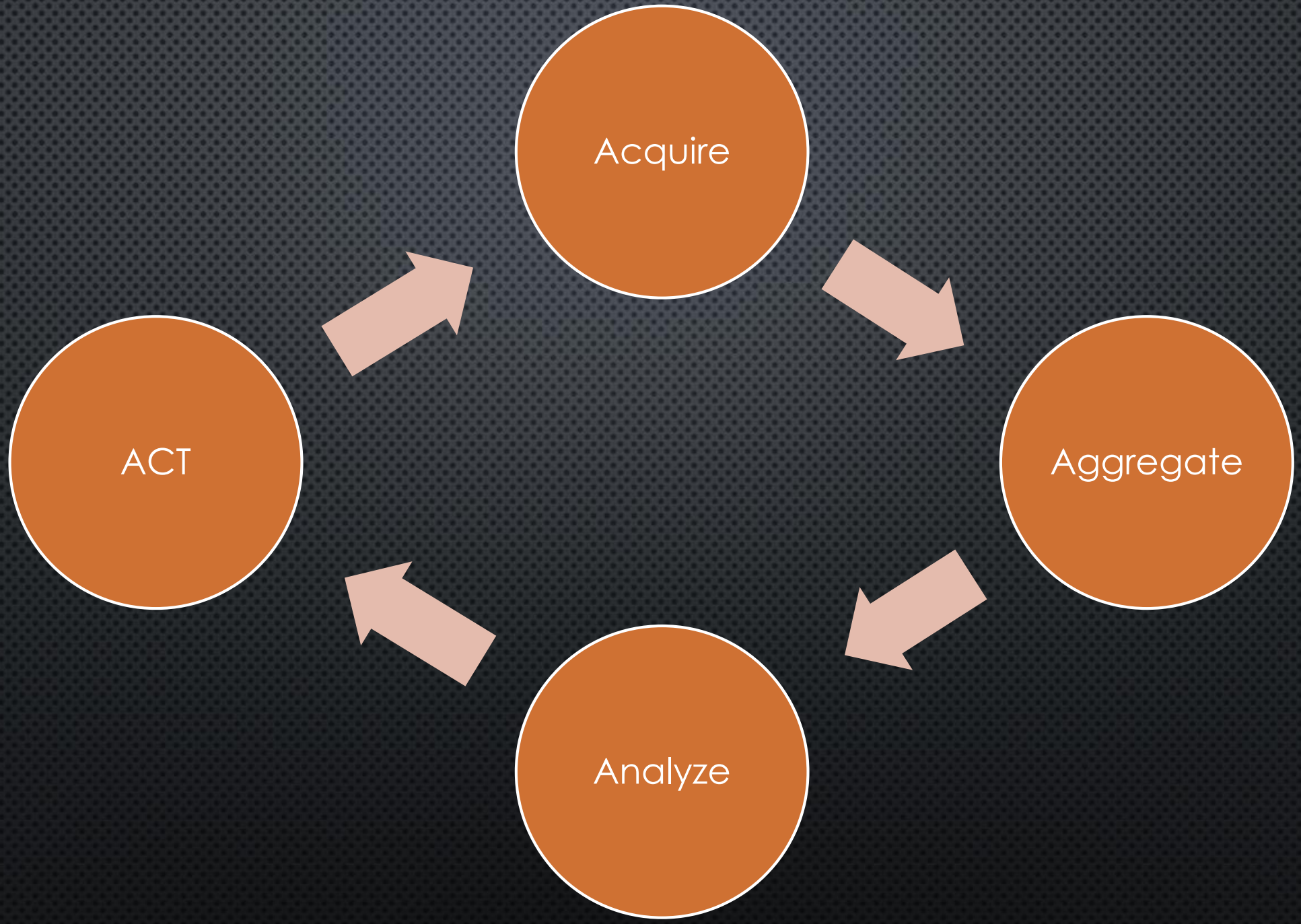
INFORMATION
TECHNOLOGY

3 Domains
Social Care
Behavioral Health Care
Medical Care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SOCIAL NEEDS

Identify

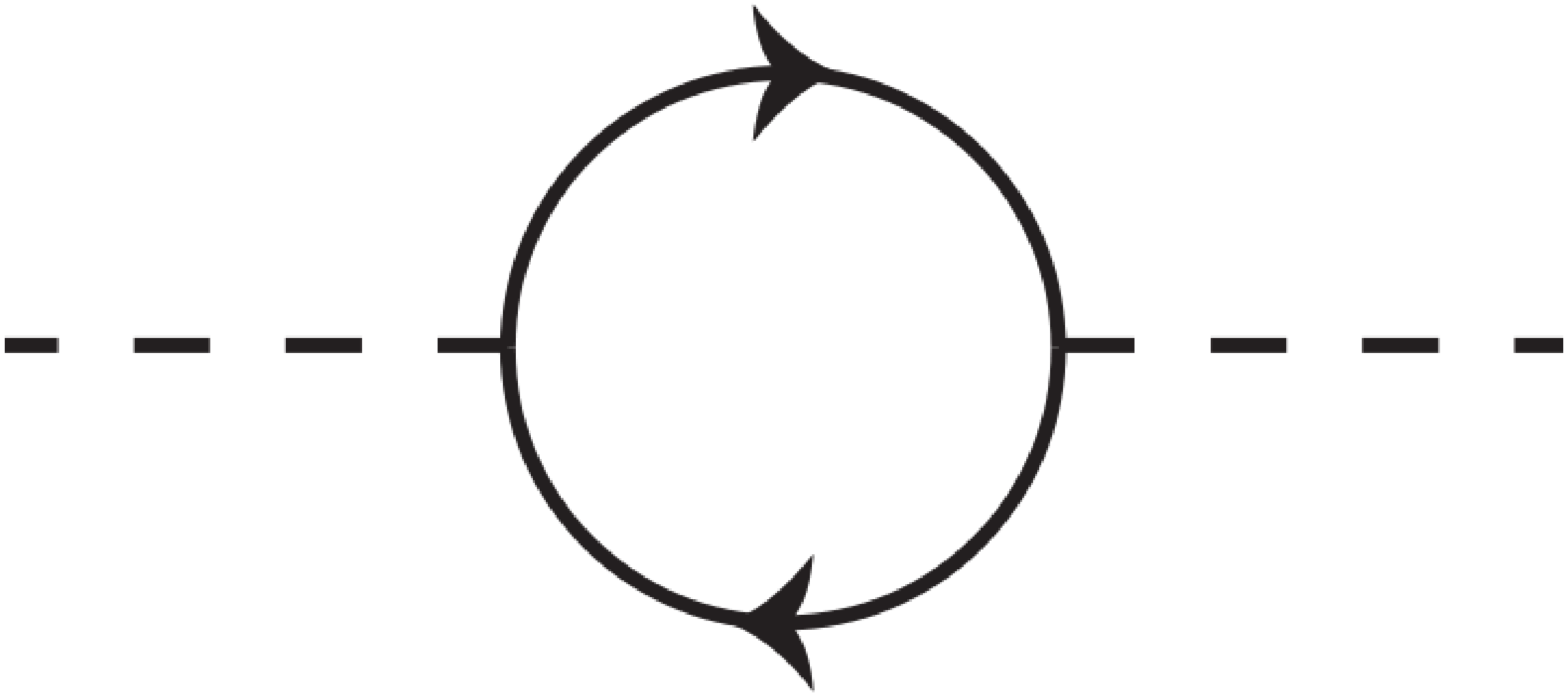
Understand

Act

Act

COMMUNICATE

CONFIRM



TECHNOLOGY

Screening

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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

ab
aunt
bertha

UNITE US

NOWPOW

CONNIE

Fade to Connie | MATCH
matchouston.org

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

Connie Talbot - Wikipe...
en.wikipedia.org

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en.wikipedia.org

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

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Q&A: 'Nashville' Actress Connie Britton...
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Emmy® Award-Nomina...
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Country Music | Connie Smith Biography ...
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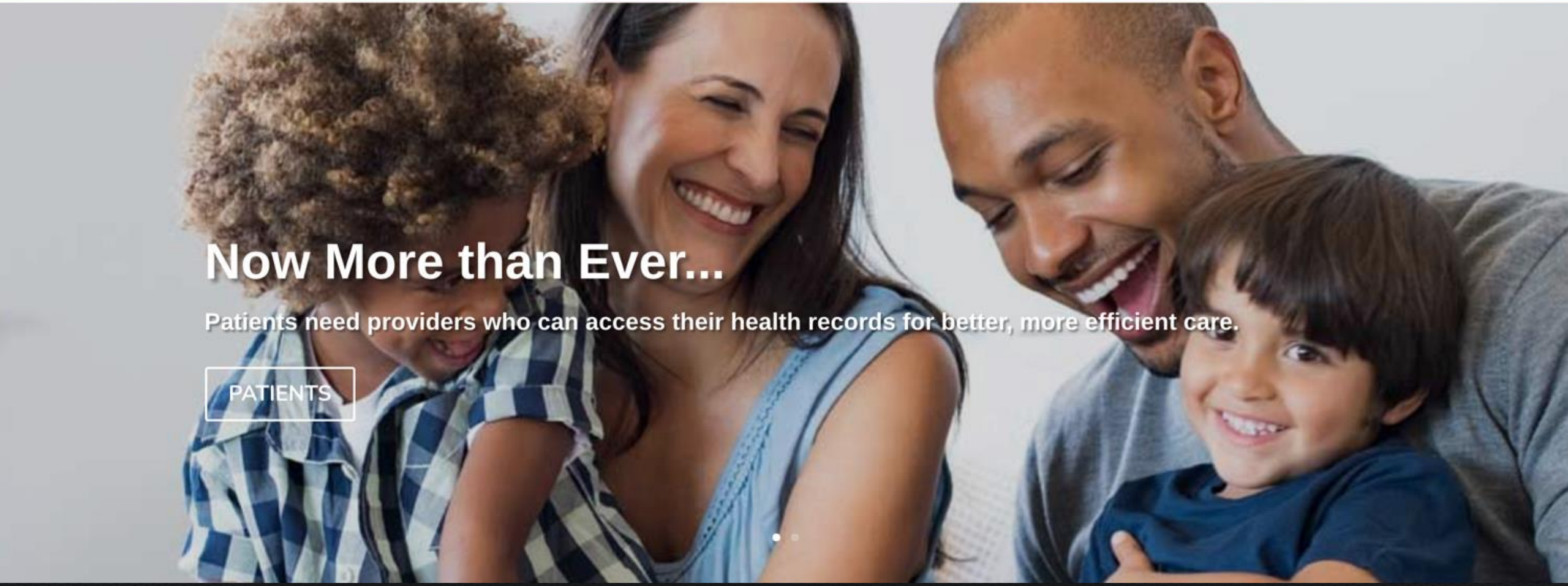

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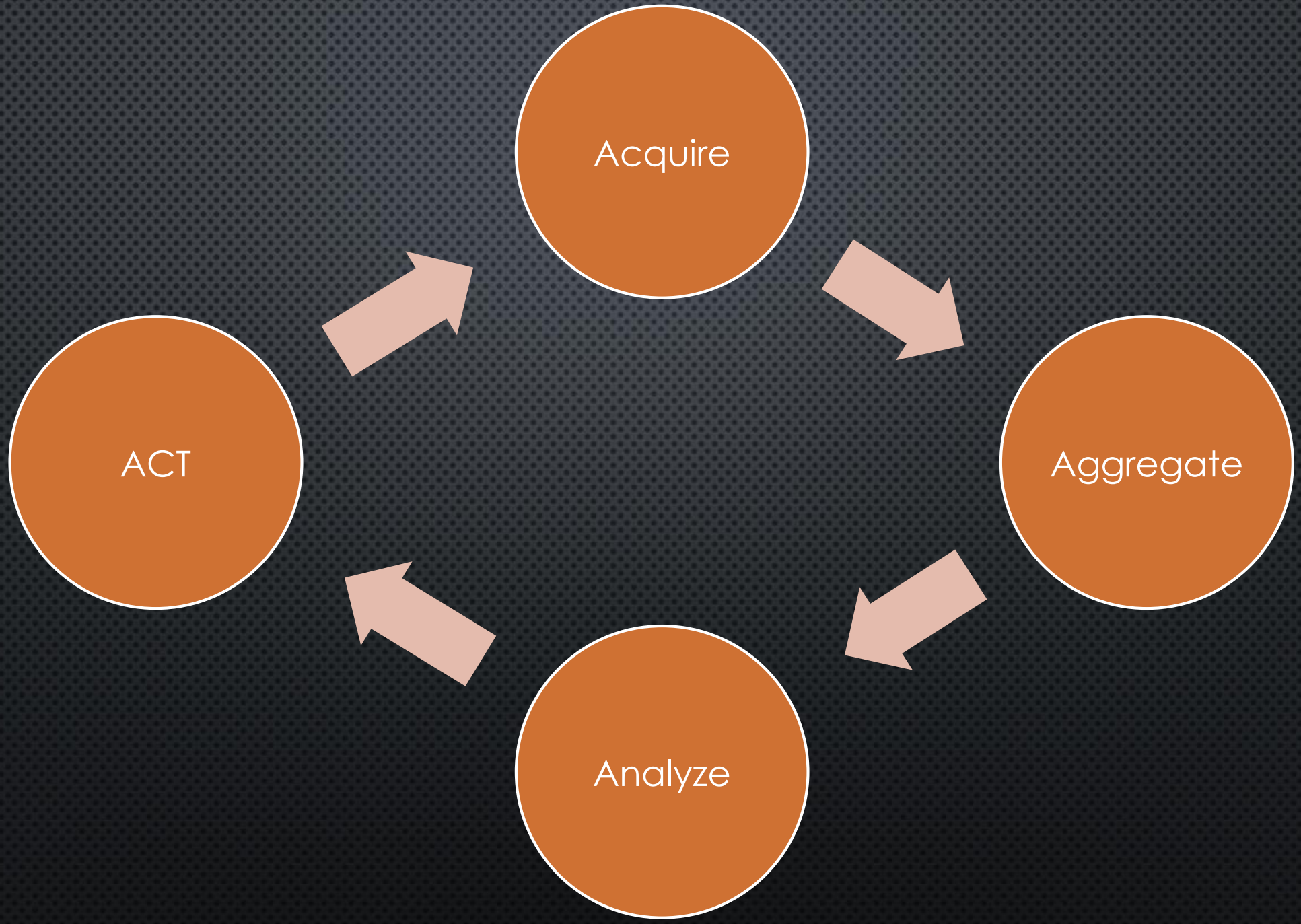
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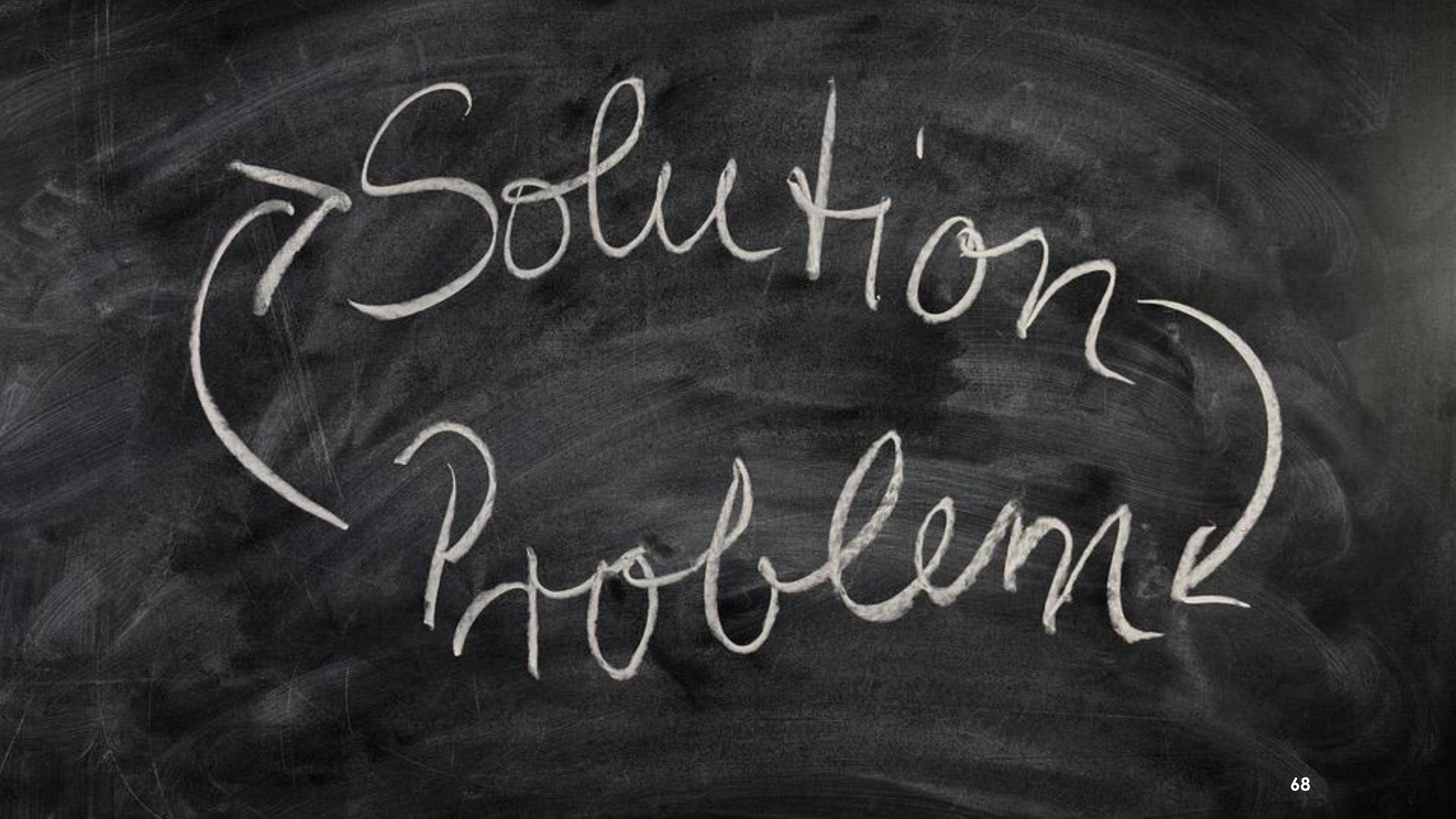
Solution
Problem

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

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Questions

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

Stay tuned for the next event!

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