Assessing and Addressing Social Determinants of Health at the University of Kansas Health System Primary Care Clinics

Jennifer Woodward, MD, MPH
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Kansas Public Health Grand Rounds
Disclosures

I have no actual or potential conflict of interest in relation to this program/presentation.
About Me

- Jennifer Woodward, MD, MPH
- KUMC SOM 2010
- Family Medicine UMKC
- Preventive Medicine University of Colorado
- Currently in the Department of Family Medicine at Kansas City Campus with joint appointment in Department of Preventive Medicine
- Practice ambulatory primary care and health system population health project
- jwoodward@kumc.edu
Objectives

• Understand Social Determinants of Health (SDOH) impact on health outcomes

• Review some examples of available tools to screen for SDOH

• Outline the process and timeline of SDOH screening at TUKHS primary care clinics

• Review TUKHS lessons learned and preliminary outcomes
Social Determinants of Health
Definitions

Healthy People 2020:

Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
Beyond Medical Care

Impact of different factors on health outcomes.

Top essential needs that impact health.

https://healthleadsusa.org/
Background

Primary Care Practices and SDOH Requirements
Our Primary Care Practices

- Primary care practices located in Kansas City metropolitan area
  - 10 CPC+ Practices (9 Track 2, 1 Track 1)

- Primary Care Patient Population: 90,000

- Electronic Health Record: Epic
Comprehensive Primary Care Plus

• Five-year Center for Medicare and Medicaid Services (CMS) advanced alternative payment model focused on quality and comprehensive care

• Year 1 (2017)
  – Systematically assess patients’ psychosocial needs using evidence-based tools
  – Conduct an inventory of resources and supports to meet patients’ psychosocial needs

• Year 2 (2018)
  – Address common psychosocial needs for at least your high-risk patients
  – Routinely assess patients’ psychosocial needs
  – Prioritize common needs in your practice population, and maintain an inventory of resources and supports available to address those needs
  – Establish relationships with at least two resources and supports that meet patients’ most significant psychosocial needs

https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus
Where We Started
Our Rules from the Beginning

• Don’t start from scratch: use validated questions or tools

• Questions need to be written at reasonable health literacy level

• Don’t screen for things that we can’t provide resources for

• Tool needs to be simple and manageable to assess and address in a 15 minute visit

• Pilot first, then expand

• Continuous quality improvement
Reviewing the SDOH Screening Tools

- There are many great validated, evidence-based tools out there
- Considerations include workflows, length of visits, availability to provide resources for positive findings, patient population preferences
Health Leads

• Provides a freely-available, modifiable screening toolkit

• Questions pull from a variety of other validated resources

• Updated regularly

• Multiple languages

• 8 content questions, all yes/no

https://healthleadsusa.org/
• National Association of Community Health Centers

• Freely available online and contains resources, best practices, and lessons learned

• 21 questions, some are demographic

**Upstream Risks Screening Tool & Guide**

"Everyone deserves the opportunity to have a safe, healthy place to live, work, eat, sleep, learn and play. Problems or stress in these areas can affect health. We ask our patients about these issues because we may be able to help."

<table>
<thead>
<tr>
<th>Domain*</th>
<th>Minimum Frequency</th>
<th>Question</th>
<th>Response</th>
<th>Suggested Scoring</th>
<th>Referral Plan Complete?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>First visit</td>
<td>1a. What is the highest level of school you have completed? Check one.</td>
<td>Elementary School</td>
<td>+1 for &quot;Elementary School&quot;</td>
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<td>High School</td>
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<td>College</td>
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<td>Graduate / Professional School</td>
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<td>1b. What is the highest degree you earned? Check one.</td>
<td>High school diploma GED</td>
<td>+1 for &quot;High School Diploma, GED, or Vocational Certificate&quot;</td>
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<td>Vocational certificate (post high school or GED)</td>
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<td>Associate’s degree (junior college)</td>
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<td>Bachelor’s degree</td>
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<td>Master’s degree</td>
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<td>Doctorate</td>
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<td>Education</td>
<td>First visit &amp; annually</td>
<td>1c. Are you concerned about your child’s learning, performance, or behavior in school?</td>
<td>YES</td>
<td>+1 for YES</td>
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<td></td>
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<td>NO Not applicable</td>
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<td>2. Choose one of the following. Which best describes your current occupation?</td>
<td>Homemaker, not working outside the home</td>
<td>+1 for &quot;Employed, but on leave for health reasons&quot;; &quot;Unemployed&quot;</td>
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<td>Employed (or self-employed) full time</td>
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<td>Employed (or self-employed) part time</td>
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<td>Unemployed, but on job search</td>
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<td>3. What is your primary source of income?</td>
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<td>4. How many hours per week do you work?</td>
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<td>(exclude self-employed)</td>
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<td>5. How many children do you have under 18 living in your home?</td>
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<td>6. What is your highest grade completed?</td>
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<td>7. What is your highest degree earned?</td>
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<td>8. What is the highest level of school you have completed?</td>
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<td>9. Do you have any concerns about safety in your neighborhood?</td>
<td>YES</td>
<td>+1 for YES</td>
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<td>NO</td>
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<td>Transportation</td>
<td>First visit &amp; bi-annually</td>
<td>11. How often is it difficult to get transportation to or from your medical follow-up appointments?</td>
<td>Does not apply</td>
<td>+1 for &quot;Often&quot; or &quot;Always&quot;</td>
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<td>Never</td>
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<td>Sometimes</td>
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<td></td>
<td>Always</td>
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<td>Exposure to Violence</td>
<td>First visit &amp; annually</td>
<td>12. Do you have any concerns about safety in your neighborhood?</td>
<td>YES</td>
<td>+1 for YES</td>
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<td>NO</td>
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<tr>
<td>Exposure to Violence</td>
<td>First visit &amp; annually</td>
<td>13a. Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?</td>
<td>YES</td>
<td>+1 for YES</td>
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<td>NO</td>
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<td>13b. Within the last year, have you been afraid of your partner or ex-partner?</td>
<td>YES</td>
<td>+1 for YES</td>
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<td>NO</td>
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<td>13c. Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?</td>
<td>YES</td>
<td>+1 for YES</td>
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<td>NO</td>
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<td>13d. Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?</td>
<td>YES</td>
<td>+1 for YES</td>
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<td></td>
<td></td>
<td>NO</td>
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<tr>
<td>Stress</td>
<td>First visit &amp; bi-annually</td>
<td>14. Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his/her mind is troubled all the time.</td>
<td>Not at all</td>
<td>+1 for &quot;Somewhat&quot;, &quot;Quite a bit&quot;, or &quot;Very Much&quot;</td>
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<td>A little bit</td>
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<td>Somewhat</td>
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<td>Quite a bit</td>
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<td></td>
<td>Very much</td>
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</tbody>
</table>

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*For more information, visit [HealthBegins.org](https://www.healthbegins.org/)

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**Key Points**

- **15 domains**
- **28 questions**
- **Update due out in 2019**
Accountable Health Communities Model

- Center for Medicare and Medicaid Services
- 10 core questions
- Freely available

EveryONE Project

- American Academy of Family Physicians
- Short and long form available

https://www.aafp.org/patient-care/social-determinants-of-health/everyone-project.html
Our SDOH Process
SDOH Overview

• Social workers are integrated into the primary care clinics to assist with community resource needs

• All patients are screened annually with 13 questions total (questions are based off of the Health Leads tool with some modifications)

• We offer the option for patients to answer the questionnaire on MyChart or on paper in-clinic

• Our pediatric departments use a different questionnaire and different workflow
Social Questions
Thank you for trusting us with your care; it is important to us. We know that social stressors can affect your life. The questions below address challenges that may be affecting you. If you answer “yes” to any of the questions, you will receive printed resources after your visit. If you would like a team member to talk to you, please answer “yes” at the bottom.

In the last 12 months, did you ever eat less than you should because there wasn’t enough money for food?  YES  NO

In the last 12 months, has your utility company shut off your service for not paying your bills?  YES  NO

Are you worried that in the next 2 months you may not have stable housing?  YES  NO

Are you afraid you might be hurt in your home by someone you know?  YES  NO

Are you afraid you might be hurt in your apartment building or neighborhood?  YES  NO

Do problems getting child care make it difficult for you to work or study?  YES  NO

In the last 12 months, have you needed to see doctor, but could not because of cost?  YES  NO

In the last 12 months, did you skip medications to save money?  YES  NO

In the last 12 months, have you ever had to go without health care because you didn’t have a way to get there?  YES  NO

Do you have problems understanding what is told to you about your medical conditions?  YES  NO

Do you often feel that you lack companionship?  YES  NO

If you answered YES to any question above, would you like to discuss them with your care team?  YES  NO

Are any of your needs urgent? (For example: I don’t have food tonight; I don’t have a place to stay tonight?)  YES  NO
SDOH Workflow: Pre-Visit

• A patient will either answer the questionnaire in MyChart (will be available within 7 days of the scheduled appointment)

OR

• The patient will answer the questionnaire using the paper form during clinic and answers entered into EHR during rooming process

• If the patient has already completed the questionnaire in the past 365 days, they are exempted
SDOH Workflow: Day of Visit

- Nurses review and file MyChart questionnaire answers and/or enter paper form answers
- Urgent needs are addressed on the day of visit if possible
- Provider reviews responses in EHR and discusses with patient
**SDOH Workflow: Positive Responses**

- If a patient answers YES to a social need, they will receive community resources that are automatically populated to the after-visit summary.
SDOH Workflow: Reporting Workbench
## SDOH Timeline

<table>
<thead>
<tr>
<th>April 2017</th>
<th>April-Oct 2017</th>
<th>October 2017</th>
<th>April 2018</th>
<th>May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Chose Tool: Health Leads</td>
<td>• IT development of flowsheet</td>
<td>• SDOH – use of paper form in clinic went live</td>
<td>• Reporting workbench built to track responses (replaces report sent every 2 weeks to social worker)</td>
<td>• Added social isolation question</td>
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<td>• Introduced tool to PFAC for feedback</td>
<td>• Paper form entered into flowsheet by rooming nurse</td>
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<td>• MyChart Questionnaire for SDOH went live</td>
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<td>• Social workers received report of responses every 2 weeks</td>
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<td>• Started screening all patients (annually)</td>
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<td>• Piloted workflow with new patients only</td>
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</table>
Challenges/Lessons Learned

• Avoiding asking patients questionnaire multiple times: pilot and optimize workflows

• Include “decline” option if possible

• Some patients do not want help with their needs

• Results needs to be visible to providers

• Staff and provider communication engagement is important

• Automation is ideal, follow up is important and appreciated
SDOH Results to Date
Percent positive through March 4, 2019

N = ~43,300 unique patients  Participants with at least one positive response: ~13,400 (31%)
Social Determinants of Health Needs 10/01/2017 – 03/04/2019
Total yes answers: ~11,800 out of ~473,000 questions asked = ~ 2.5% total positivity rate

11,882 Yes answers out of a potential 473,366 questions, equals positivity of 2.5%.
Future Plans

• Continue to optimize
  – Patient experience
  – Expand to other languages
  – Workflow
  – Community resources
  – Provider engagement
  – EHR best practices

• Continue to analyze and understand SDOH role on our patient’s lives and health and how to best respond as a health system
References/Acknowledgements

• References available on specific slides
• Dr. Ed Ellerbeck, Preventive Medicine
• Dr. Ryan Smith, Pediatrics
• Joy Jacobsen, Director, Ambulatory Quality
• Megan Murray, Clinical Data Analyst, Family Medicine
• Lauren Sawatzky, Program Manager, Ambulatory Quality
• John Yourdon, Data Analyst, Ambulatory Quality
• Natosha Tyus, Optimization Analyst
• Meredith Hughley, HITS, Clinic Analyst
• 4th year Medical Students (many)
• And many others!
Questions?

Don’t hesitate to reach out: jwoodward@kumc.edu