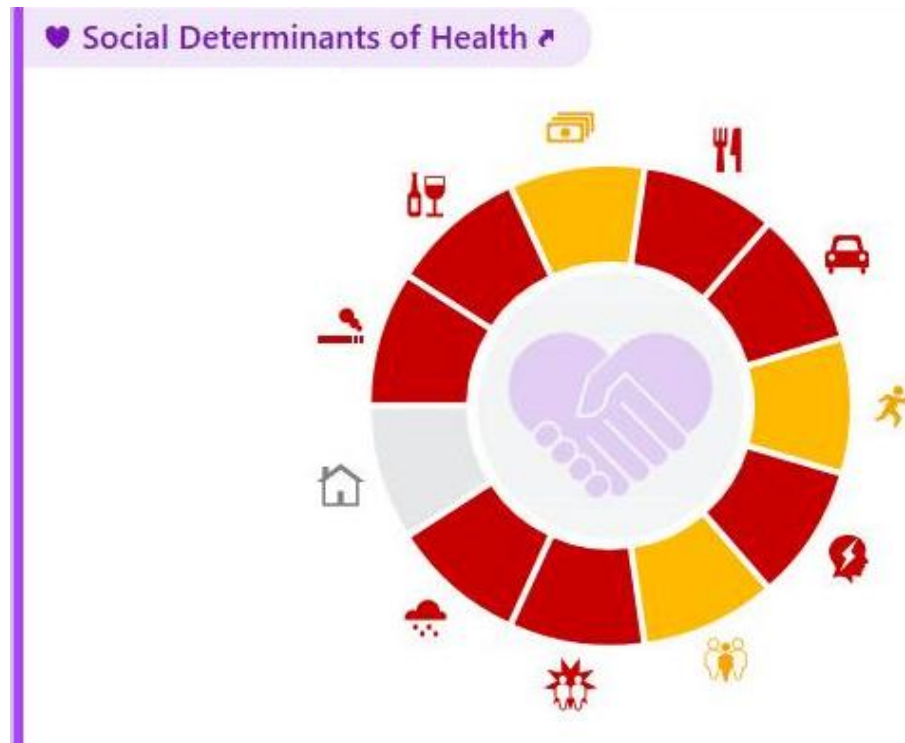


Lehigh Valley Health Network

SDOH GOALS

Goals:

1. Alignment of all agencies interacting with patients
2. Use National SDoH screening tool built in Epic
3. Completed by patients to identify needs
4. Data is collected from the survey and resources provided



National Academy of Medicine:

- Alcohol Use
- Depression
- Financial Resource Strain
- Intimate Partner Violence
- Physical Activity
- Social Isolation
- Stress
- Tobacco Use

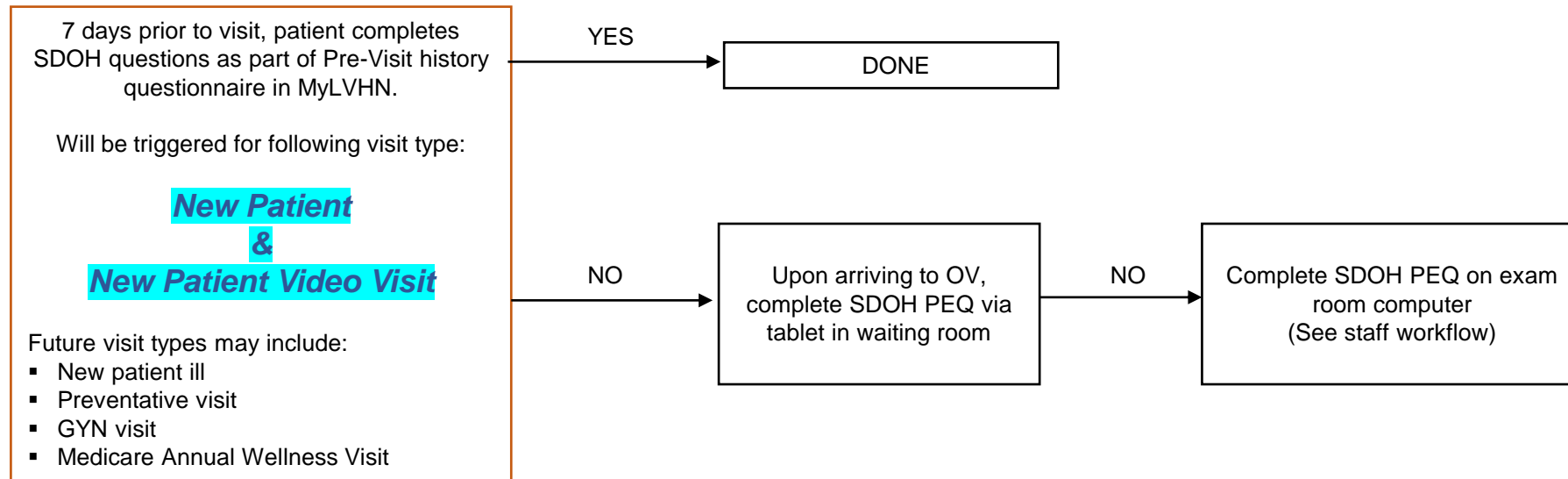
Added based on customer feedback:

- Food Insecurity
- Transportation Insecurity

Current Pilot: Select Practices, New Patients

- Operationalize Adding a New Layer of Work.
- Assess Patient Response.
- Assess Practice Compliance.
- Assess Technology Deficiencies.
- Feedback on Improvement.

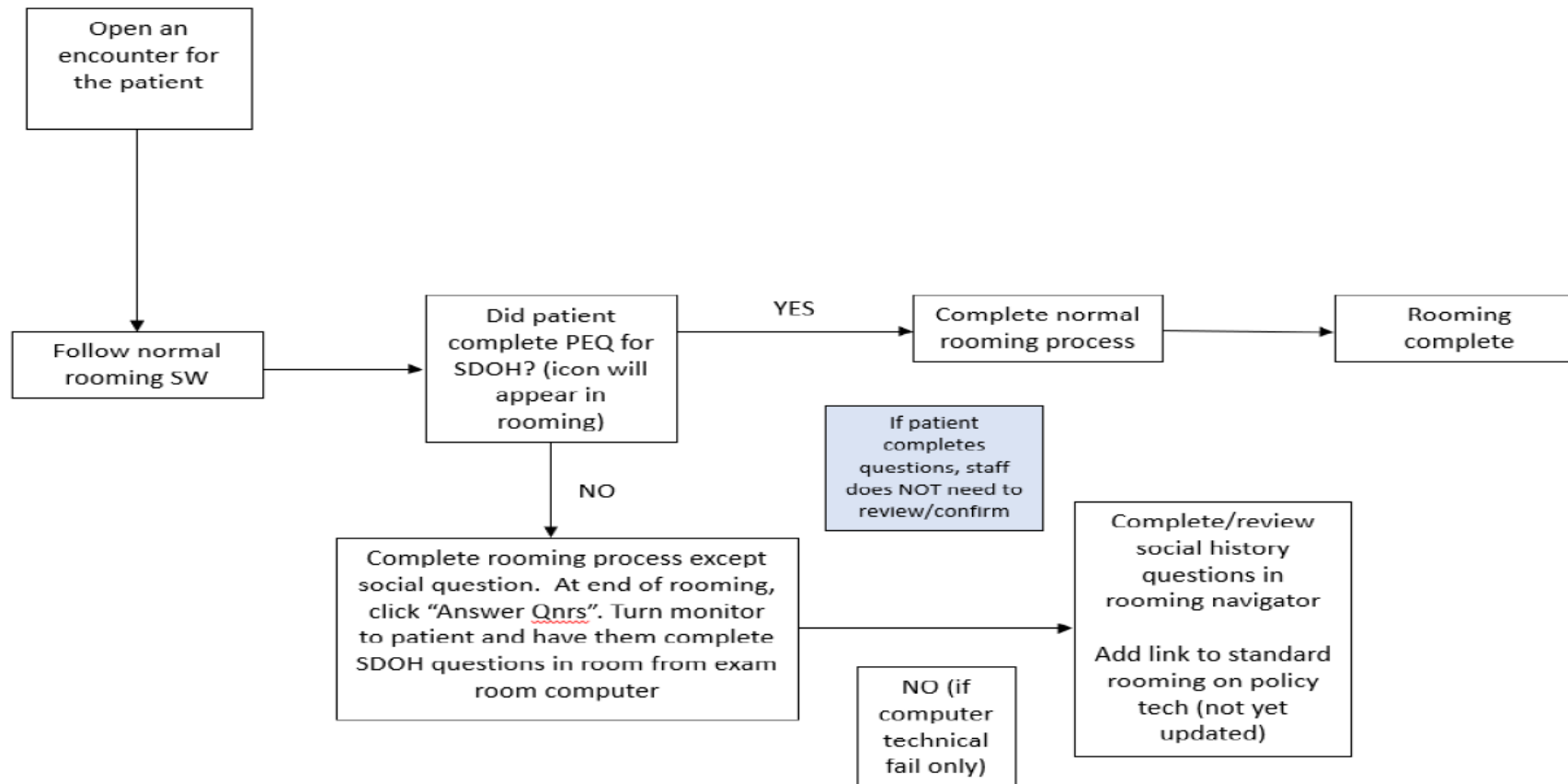
Option 1: Patient Completes Before Visit



Spanish Patient-Entered Questionnaires (PEQs)

Option 2: Patient Completes at Visit

Workflows for Clinical Staff



Option 3: If Pre-visit or Day-of Self-Completion are Not Achieved, then Rooming Staff Complete

GENERAL
Medical
Surgical
Family

SOCIAL DETERMINANTS
Substance & Sexual...
Socioeconomic
Lifestyle
Relationships
Social Documentation

SPECIALTY
Birth

Substance & Sexual Activity

Tobacco

Smoking Status: ⚠️ 🔍

Smokeless Tobacco: ⚠️ 🔍

Start Date: m/d/yyyy 📅

Types:

Quit Date: m/d/yyyy 📅

Types:

Packs/Day: 📅

Number of Years: 📅

Pack Years: 0

Counseling Given:

Comments:

Alcohol

Alcohol Use:

How often do you have a drink containing alcohol?

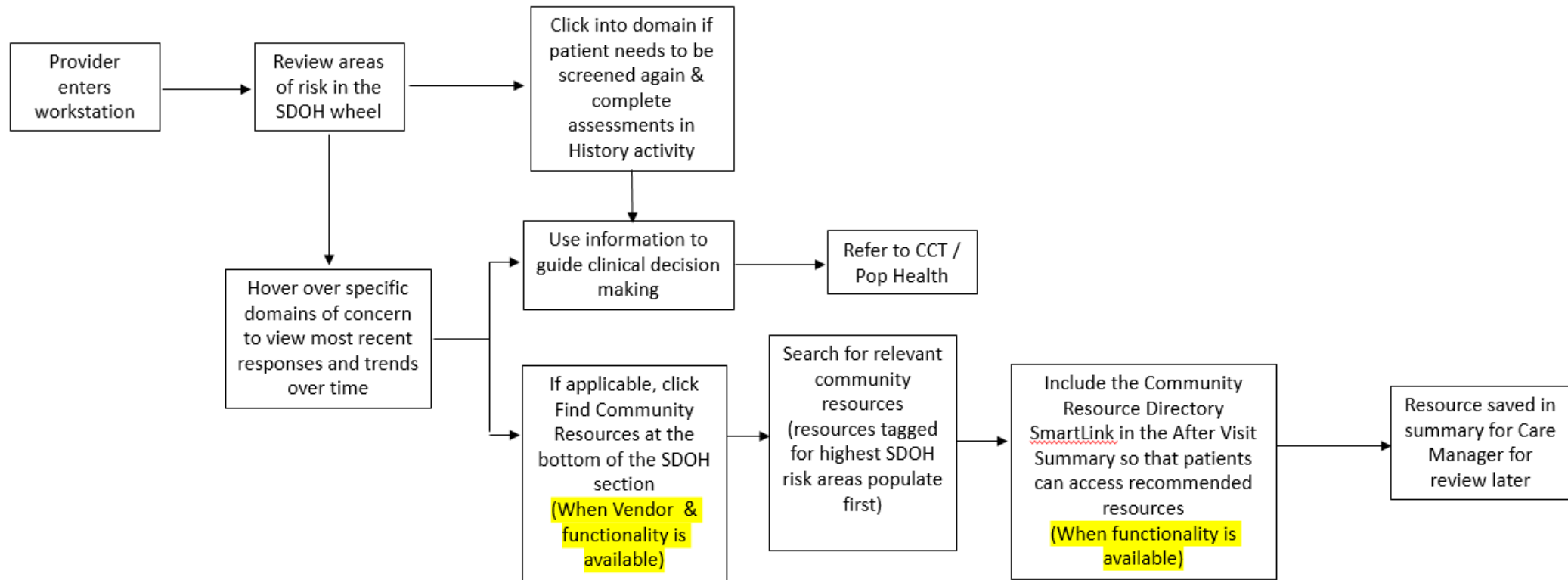
How many drinks containing alcohol do you have on a typical day when you are drinking?

How often do you have six or more drinks on one occasion?

Drinks/Week: Glasses of wine
 Cans of beer
 Shots of liquor

Provider Workflow: Present and Future State

Workflows for Provider



Early Feedback from Pilot Sites

- Additional time to room is increased, but not prohibitive.
- There is variation practice to practice as to which avenue is seen as most valuable (previsit questionnaire, waiting room, exam room).
Varies based on patient population and practice culture.
- Providers like the look and speed of seeing the color wheel.

EPIC Functionality is Built on a “Patient Level,” not an “Encounter Level.”

The screenshot displays a patient's medical record in the EPIC system. The interface is organized into several panels:

- Allergies:** A section titled "Allergies" with a sub-header "Enable clinical decision support by reconciling outside information". It lists two categories: "Penicillins (Requested for removal by patient) Medium - No reactions specified" and "Sulfa Antibiotics No severity or reactions specified".
- Problems:** A section titled "Problems" with the same sub-header. It lists three conditions: "Asthma (Requested for removal by patient) Patient I have never had asthma." noted 1 month ago; "Ankle sprain" noted 5 months ago; and "Hypertension" noted 1 year ago.
- Social Determinants of Health:** A central panel titled "Social Determinants of Health" featuring a circular infographic with 12 segments representing different factors like housing, food, and transportation. Below the infographic are links for "Find community resources" and "View previous recommendations".
- Care Team:** A section listing two providers: "Williams, Aaron, MD PCP - General, Family Practice" (Started 2 months ago, 608-271-9000) and "Sutton, Robert T., MD Physician, Family Practice" (Started 5 months ago, 608-777-5555).
- Recent Visits:** A section listing three visits: "NOV 28 2017 Office Visit Family Practice - Robert Sutton, MD", "NOV 14 2017 Office Visit Family Practice North - Amy B Saracino, Pharmacy Technician", and "SEP 25 2017 Office Visit Family Practice - Robert Sutton, MD". A link "Open Chart Review to see information about additional visits" is provided.
- Outpatient Medications:** A section at the bottom with a "Meds Overview" link.

Social Determinants: (Future Story Board)

The screenshot displays a patient record for Quebec Conway, a 29-year-old female born on 3/19/1989. The record includes a navigation bar with tabs for Chart Review, Call Initiation, Care Mgmt, Problem List, and Social Determinants of Health. The main content area is titled "1/8/2019 visit with Nurse Care Manager, RN for Patient Outreach" and features a "Social Determinants of Health" section. This section is highlighted with a red box and contains a grid of 12 items, each with an icon, a title, a date (JAN 8 2019), and a risk level. The items are: Tobacco Use (High Risk), Alcohol Use (Heavy Drinker), Financial Resource Strain (Medium Risk), Food Insecurity (Food Insecurity Present), Transportation Needs (Unmet Transportation Needs), Physical Activity (Sufficiently Active), Stress (Stress Concern Present), Social Connections (Moderately Isolated), Intimate Partner Violence (Not At Risk), and Depression (At risk). A "Depression" tag is also visible in the left sidebar. The sidebar also shows the patient's physician (Family Medicine PCP), insurance coverage (AETNA/AETNA - GEN...), and risk scores (43% Admission or ED Risk, 11% Hypertension Risk). A "CARE GAPS" section indicates no care gaps to address.

Quebec Conway
Female, 29 y.o., 3/19/1989
MRN: 205958
Code: Assume Full (no ACP docs)

Isolation: None
Physician Family Medicine PCP
Coverage: AETNA/AETNA - GEN...
Allergies: Not on File

SOCIAL DETERMINANTS

RISK SCORES
43% Admission or ED Risk
11% Hypertension Risk

CARE GAPS
No care gaps to address

Social Determinants of Health

Category	Item	Date	Risk Level
Tobacco Use	Tobacco Use	JAN 8 2019	High Risk
	Alcohol Use	JAN 8 2019	Heavy Drinker
	Financial Resource Strain	JAN 8 2019	Medium Risk
Transportation Needs	Transportation Needs	JAN 8 2019	Unmet Transportation Needs
	Food Insecurity	JAN 8 2019	Food Insecurity Present
	Physical Activity	JAN 8 2019	Sufficiently Active
Stress	Stress	JAN 8 2019	Stress Concern Present
	Social Connections	JAN 8 2019	Moderately Isolated
	Intimate Partner Violence	JAN 8 2019	Not At Risk
Depression	Depression	JAN 8 2019	At risk

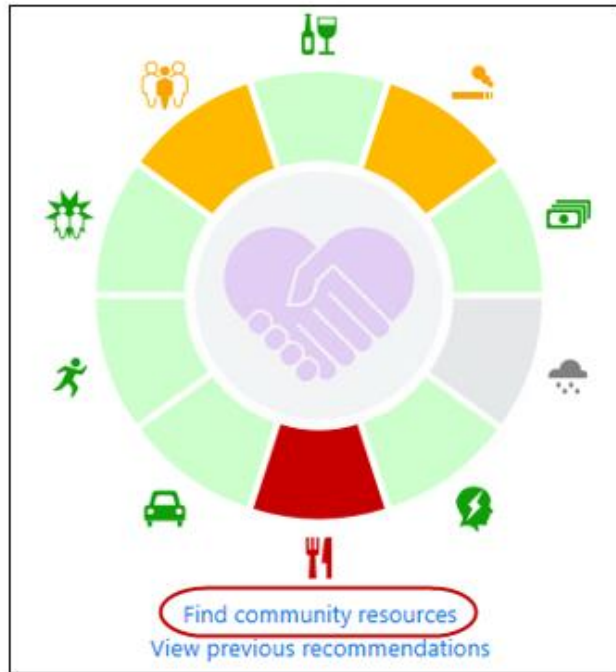
Find community resources

Present State: Utilize Internal Population Health Community Care Team (CCT)

- CCTs are multidisciplinary teams working collaboratively with primary care and specialty practices to offer care coordination and management of the high-risk patient population
- Interdisciplinary care teams inclusive of:
 - Nurse Care Managers
 - Behavioral Health
 - Social Worker/Social Service Coordinators
 - Clinical Pharmacists
 - Medication Assistance and Community Health Workers
- Deployed to all LVPG local primary care

Future State: Integration with State Vendors

On the Wheel- the link is below
When vendor (Aunt Bertha) and functionality is available



Community Resource Directory- sample view

Community Resources

Search by name Home - 342 7th st, VERONA WI 53593

Filter by

- Favorite
- My favorites
- Provided Service
- Elder Community Supp...
- Financial Assistance
- Food Insecurity Serv...
- Housing Insecurity Serv...
- Mental Health Services
- Substance Use Services
- Transportation
- Visiting and Companio...
- Youth Community Supp...

Showing results near 342 7th st, VERONA WI 53593. Including results with no address. Filtered by: Provided Service

Service	Address
EMC PED PSYCHIATRY	123 Anywhere Street VERONA WI 53593-9179
EMC PSYCHIATRY	123 Anywhere Street VERONA WI 53593-9179
EMH PSY DAY TREATMENT	123 Anywhere Street VERONA WI 53593-9179
EMH PSYCHIATRY	123 Anywhere Street VERONA WI 53593-9179

Selections (1)

- EHS MEDICAL TRANSPORTATION SERVICES

Accept Cancel

Coding: Providers adding Z-codes

- Color wheels correspond to easy identification.
- Providers do need to manually add Z codes.
- We use American Hospital Association (AHA) material in compliance education to outline coding standards.
- Future state: More prescriptive crosswalk tying the wheel to codes?