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Researchers Study How Community Health Centers Can Use EHRs to Track and Act on Patients' Social Determinants of Health

By Rachel Gold, PhD, MPH

What's going on?

Researchers from Kaiser Permanente NW's Center for Health Research have been studying how to help safety net community health centers (CHCs) use electronic health records (EHRs) to identify, review and act on patients' social determinants of health (SDH) needs. Rachel Gold, PhD, MPH, is leading this work in partnership with OCHIN, Inc. (a non-profit organization that provides a full range of health information technology services to CHCs; www.ochin.org), and researchers from Oregon Health & Science University.

Why conduct this research?

If CHCs could systematically document their patients' SDH needs, and SDH-related referrals to community social services or adaptations to the care plan, clinical teams could better integrate patients' social and medical needs, improve health outcomes, and mitigate health disparities. Though CHCs have historically tried to address the SDH impacting their patients, these attempts rarely involved clear documentation of SDH-related information. SDH-related data must be integrated into EHRs if they are to have clinical utility.

What is being studied?

Working with three CHCs and OCHIN's clinical leadership, researchers developed a suite of 'SDH Data Tools' in the EHR which included: (1) data-entry 'flowsheets' accessible to most clinic staff, with a SDH survey including 14 questions (based on KP's 'Your Current Life Situation' survey and other sources), plus versions of the survey in print and in the online patient portal; (2) SDH summaries, highlighting 'positive' screening results, and past SDH-related referrals; (3) tools for referrals to community services / resources; (4) a text shortcut for documenting referrals; (5) SDH-related data rosters in the EHR's panel management tools; and (6) functions that note SDH in Problem Lists.

What was learned?

Key lessons from the SDH tool development process included:

- It is not adequate to ask about general financial strain; CHCs need to know patients' specific needs, such as food, housing, or transportation.
- SDH data tools must accommodate various workflows, data collection points and collection methods.
- It is important to recognize 'positive' SDH screening results and respond to them.
- It is helpful to document (1) patients who decline to answer SDH questions, and (2) patients with positive SDH screening results who do not want clinic assistance.
- It is beneficial to develop strategies for keeping community resource lists up to date. Consider partnering with organizations that maintain such lists.
- EHR-related referrals differ from standard clinical referrals. A standardized system for coding SDH needs is needed, but no such system currently exists nationally.

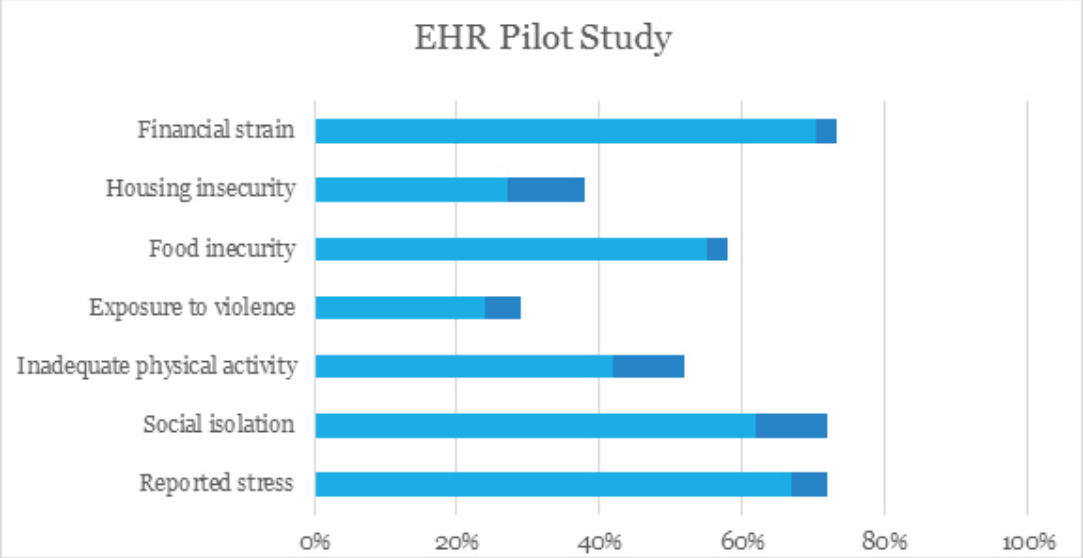
Results from Year 1 suggest that:

- It is feasible to build and implement EHR tools for SDH data collection and action in CHCs.
- CHCs will adopt such tools. At the three pilot clinics, 1,130 patients were screened within 13 months. Of those, 211 had SDH-related referrals documented in the EHR, the majority of which occurred through the SDH referral tools.
- Adoption required trial-and-error, and faced diverse implementation barriers.

Why is it important?

The need for SDH screening is profound:

Among patients screened in these community health centers, 71-73% reported financial resource strain, 27-38% reported housing insecurity, 55-58% reported food insecurity, 24-29% reported exposure to violence, 42-52% reported lack of adequate physical activity, 62-72% reported social isolation, and 67-72% reported stress.



For details, see Gold et al, JABFM, 2017

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