

# From the Clinic to the Community: Addressing the Social Determinants of Health



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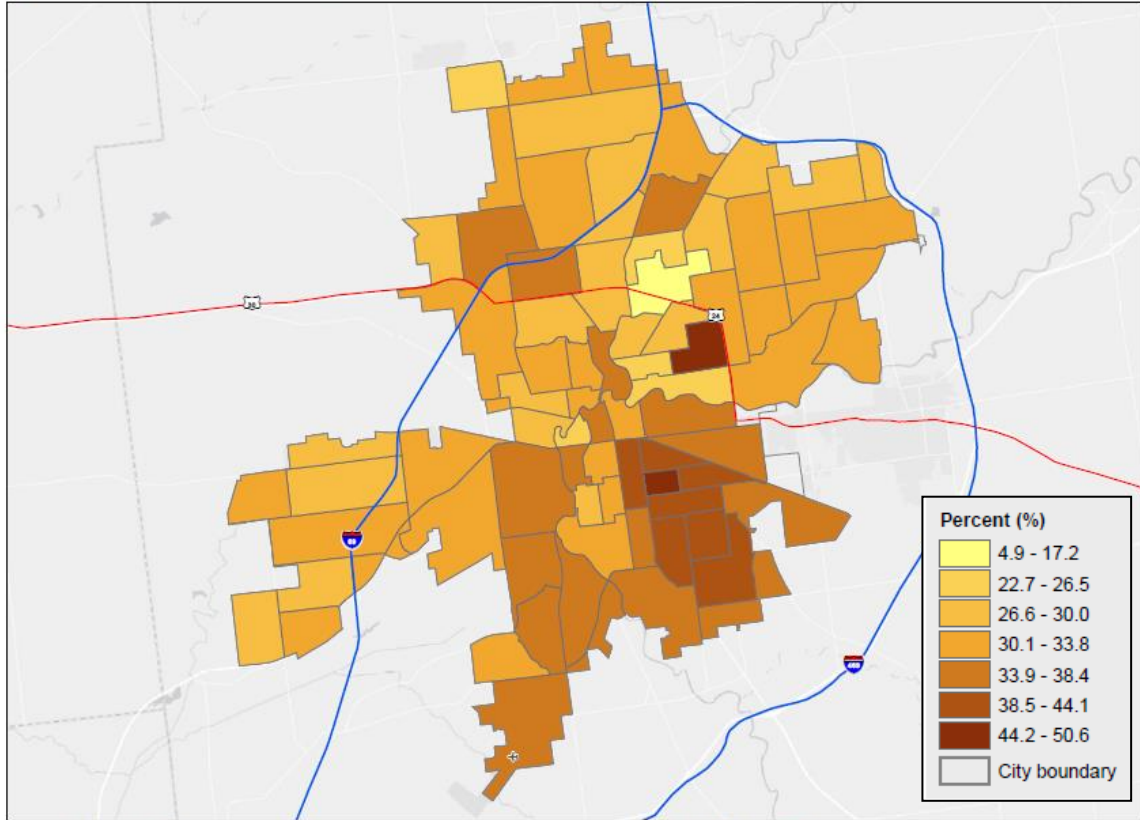
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Population Health Supervisor



# Local Health Inequity Data: Hypertension and Diabetes

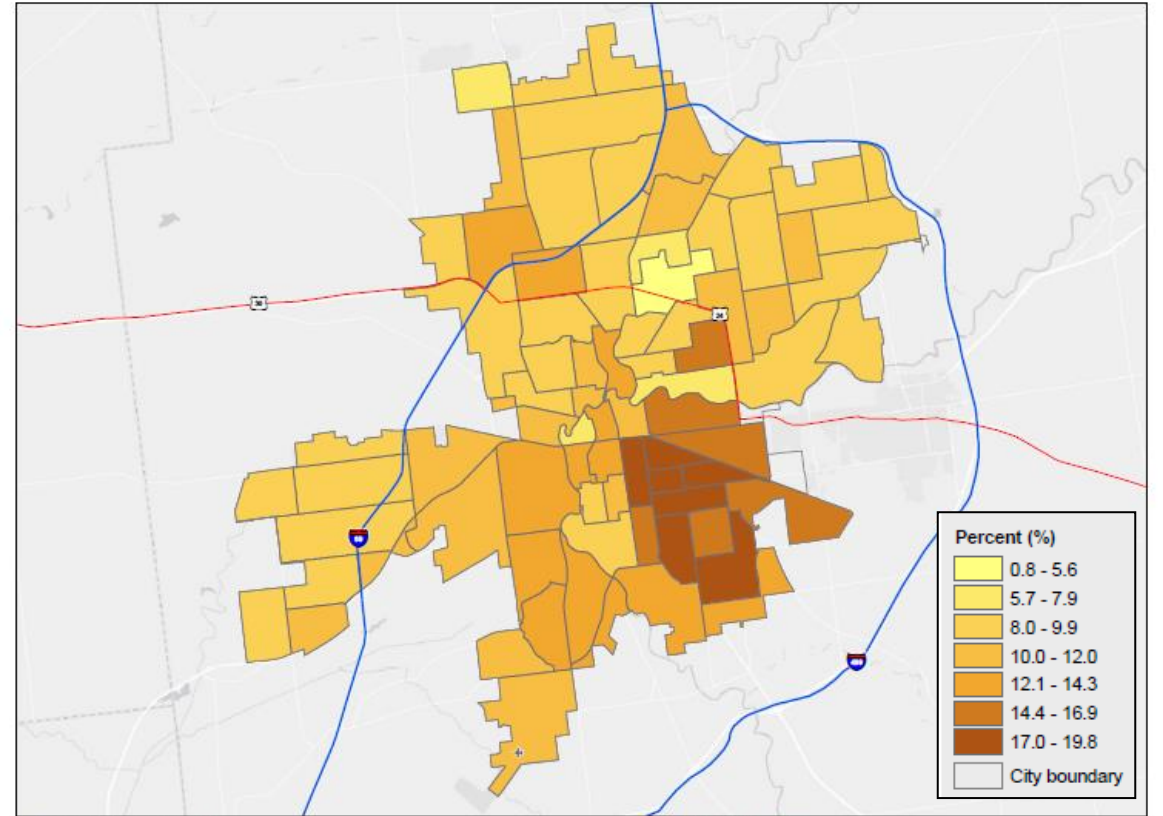
High blood pressure among adults aged  $\geq 18$  years  
by census tract, Fort Wayne, IN, 2015



Map created by CDC/NCCDPHP/EPHESB-GIS

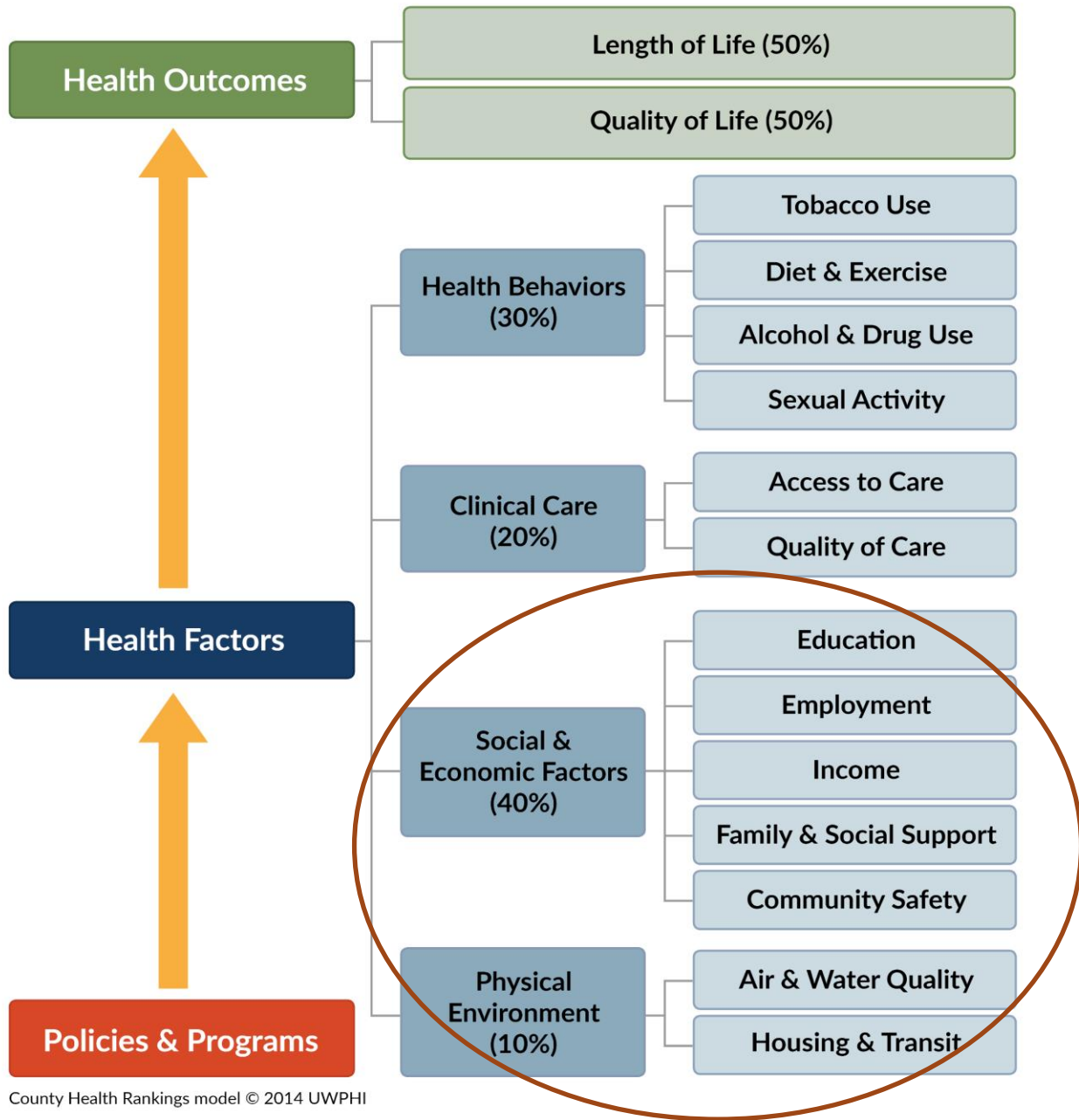
Page 240 of 500 (7/33)

Diagnosed diabetes among adults aged  $\geq 18$  years  
by census tract, Fort Wayne, IN, 2016



Map created by CDC/NCCDPHP/EPHESB-GIS

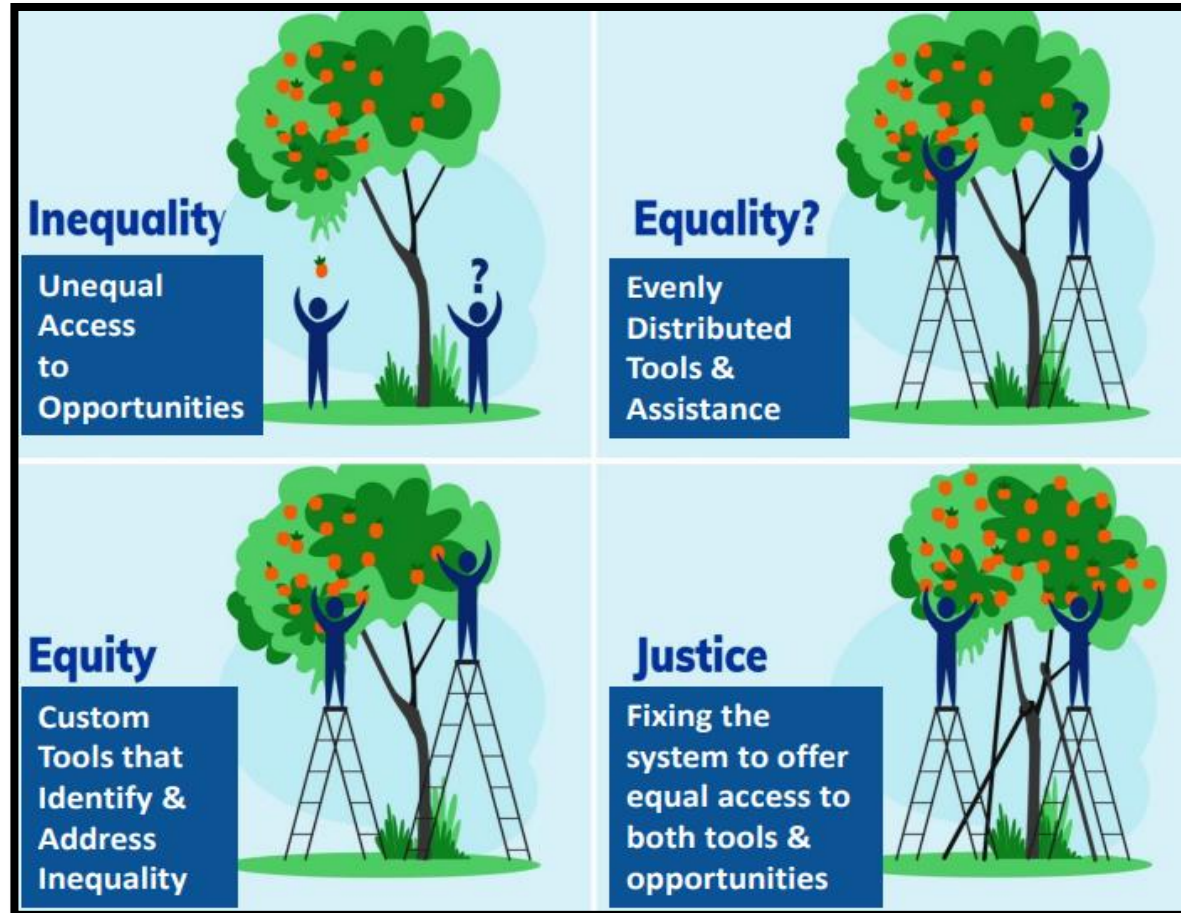
Page 240 of 500 (9/33)



## Social Determinants of Health (SDoH)

Conditions in which people are born, grow, live, work, play and age

# Social Drivers of Health and Equity



Recreated by The Busara Center from Tony Ruth's depiction of Shel Silverstein's The Giving Tree

# Background

- Parkview Health is a not-for-profit, community-based health system serving a northeast Indiana and northwest Ohio population of more than 1.3 million
  - 10 hospitals
  - Network of primary care and specialty physicians
    - 45+ clinical specialties



# Parkview's Mission and Vision

- **Mission:** *“Improve your health and inspire your well-being.”*
- **Vision:** *“You are at the center of everything we do, as an individual, as an employer and as our community.”*
- Pause – Reset – Reframe
  - Overall health and well-being stretches far beyond clinical components alone...
  - Systemwide initiative to better understand the way that we were screening for SDOH across Parkview



# The Journey

- Formal SDOH screening has been in place at Parkview for over 7 years, BUT...
  - Fragmented and siloed
  - Lack of standardization
- The absence of consistent set of screening questions + variable processes for documenting completed questionnaires = a general lack of meaningful data and conflicting opinions on the best way to screen for and address unmet social needs in patients
- **GOAL**: Standardized approach to collect, interpret, and use SDOH data across Parkview





# Research and Collaboration

- **EHR's model SDOH screening tool vs. customized list of questions?**
  - Potential barriers
    - Achieving consensus among internal subject matter experts
    - EMR build work associated with customization
- **Systemwide SDOH project**
  - Partnership with Parkview's Health Services & Informatics Research (HSIR) team and our research collaborators at the University of Michigan
  - Delphi study: consensus among a diverse group of stakeholders across the health system (questions, frequency of screening, mode of screening)
  - Customized set of validated SDOH screening questions
- **SDOH Advisory Group**
  - Mission: Gather meaningful, system-wide data and promote effective processes to address identified SDOH-related needs, which will then be used to direct community investments, system-wide health initiatives, and comprehensively promote health across our communities.



# Epic Integration

*The EHR...an integral piece of the overall puzzle!*

The screenshot displays the 'Social Determinants of Health' section in the Epic EHR interface. It features a grid of 14 items, each with an icon, a title, and a risk status. The items are arranged in two columns. The first column includes: Housing Stability (High Risk), Food Insecurity (High Risk), Transportation Needs (High Risk), Financial Resource Strain (Unknown), Health Literacy (Low Risk), Social Connections (High Risk), and Intimate Partner Violence (Low Risk). The second column includes: Childcare Access (Low Risk), Tobacco Use (High Risk), Alcohol Use (Not At Risk), Physical Activity (Sufficiently Active), Stress (Low Risk), Depression (Not on file), and Assistance Interest (Doesn't Want Assistance). Each item has a small arrow icon to its right, and there are 'Expand All' and 'Collapse All' links at the top right of the section.

Category	Risk Status
Housing Stability	High Risk
Food Insecurity	High Risk
Transportation Needs	High Risk
Financial Resource Strain	Unknown
Health Literacy	Low Risk
Social Connections	High Risk
Intimate Partner Violence	Low Risk
Childcare Access	Low Risk
Tobacco Use	High Risk
Alcohol Use	Not At Risk
Physical Activity	Sufficiently Active
Stress	Low Risk
Depression	Not on file
Assistance Interest	Doesn't Want Assistance

- Shared definition of the data
- Standard approach to interpreting and acting upon the data
- Data which is visible and accessible across the entire care team
  - SDOH SnapShot report
  - SDOH table feature

# Finalized SDOH Questions

## Sample Questions

**Food Insecurity** ⤴

Within the past 12 months, you worried that your food would run out before you got money to buy more.

⋮ ▼ 📄

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

⋮ ▼ 📄

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**Transportation Needs** ⤴

In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

⋮ ▼ 📄

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**Financial Resource Strain** ⤴

In the past year, have you or any family members you live with been unable to get medicine or any health care (medical, dental, mental health, vision) when it was really needed?

⋮ ▼ 📄

## Screening Domains

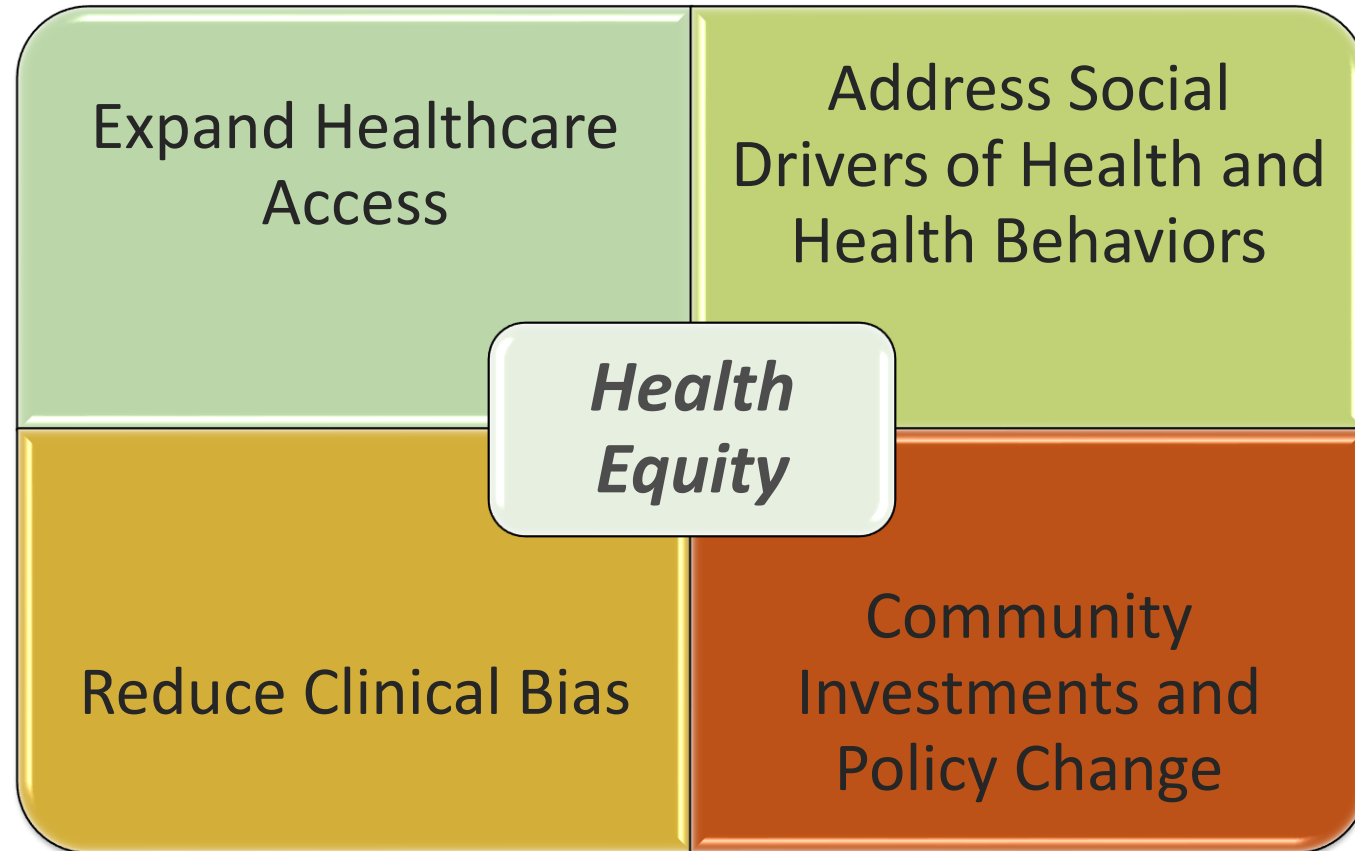
- Housing stability
- Food insecurity
- Transportation
- Financial resource strain
- Affording utilities
- Childcare access
- Health literacy
- Social connections
- Stress
- Intimate partner violence

# Clinic Workflow Implementation

- **Think Big, Start Small**
  - Prepare – Test – Spread
  - Started with 4 ambulatory pilot sites and growing OP implementation from there
  - IP implementation – preparing for new CMS measure (2024)
- Implementation “tool kit” created
- Workflows could vary between sites/service lines
  - Who introduces the screener, how it is administered, who collects it, how patient will be connected to resources, who has follow-up responsibility
- Program evaluation and monitoring is essential to ensure well-intended policies and programming do not inadvertently worsen disparities
  - User experience observations



# Parkview's Approach to Health Equity



### Expand Healthcare Access

- Community Nursing
- Community Health Workers
- Ronald McDonald Care Mobile
- CHL Check-up Days

### Community Investments and Policy Change

- Community Health Improvement Program
- Parkview Hospital Investments
- Parkview Governmental Affairs

### Address Social Drivers of Health and Health Behaviors

- Veggie RX and Greenhouse programs
- FitKids 360
- CHL programming
- School-based wellness programs
- FAST
- HEAL
- Freedom from Smoking and TFAC
- Healthy food boxes
- Senior's Club and other outreach programs

### Reduce Clinical Bias

- Organization Development and Leadership Training
- LEAD Certificate
- Analysis of Parkview Data Stratified by Race, Ethnicity, Gender, and Address

# Promoting Health through Produce Prescription

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- Veggie RX is a fruit and vegetable prescription program designed to address food insecurity and diet-related illnesses by increasing intake of fresh produce.
- All participants received monthly vouchers that could be used to purchase fresh produce from local farm markets.
- Program participants have shown improvements in blood pressure, A1C, general health, and increased fruit and vegetable consumption.



# Priority Population



Residents of Allen County with *ONE* of the following health conditions:

- Diabetes or Prediabetes
- Heart Disease (Congestive Heart Failure or Coronary Artery Disease)
- Hypertension
- At-Risk pregnancy

AND *ONE* of the following:

- Medicaid OR Dual eligible Medicare/Medicaid
- Uninsured
- **Positive screen for food insecurity questions (run out of food monthly)**



# Food Insecurity Screening

Are the following statements “often true”, “sometimes true”, or “never true” for you and/or your family during the past 12 months?



We were worried whether our food would run out before we got money to buy more.

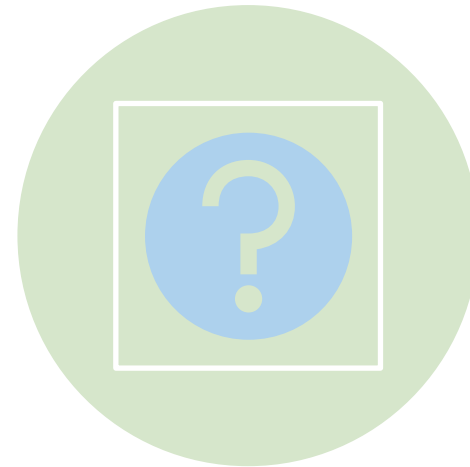


The food we bought just did not last and we did not have money to get more.

# Epic Referral



REFERRAL CODE 260 AMBULATORY  
REFERRAL TO VEGGIE RX



3 QUESTIONS

# Food Assistance and Support Team (FAST)



FOOD  
INSECURITY  
SCREENING



PROGRAM  
NAVIGATION



VEGGIE RX TO  
HEAL



FEDERAL  
ASSISTANCE  
NUTRITION  
PROGRAMS



CONSISTENT  
ACCESS/  
AVAILABILITY/  
AFFORDABILITY  
TO FOODS



**PARKVIEW**

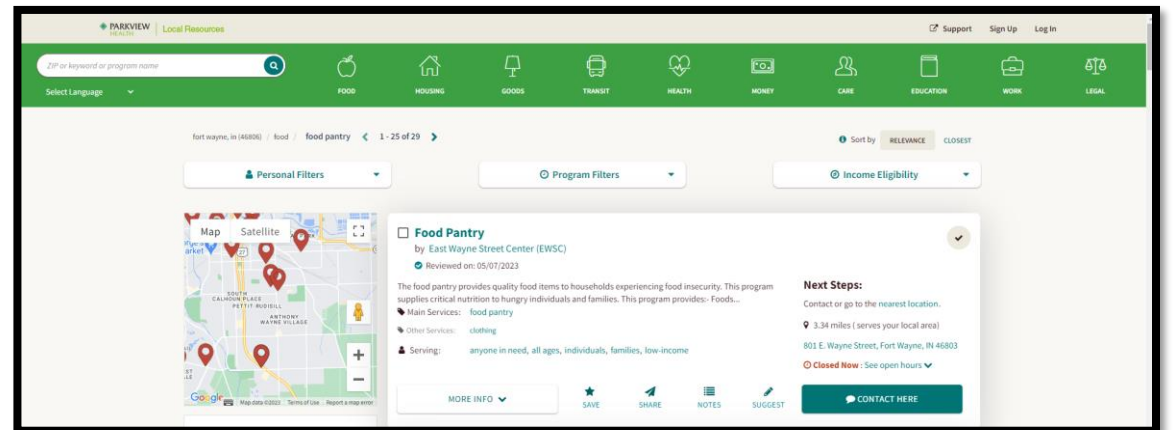
# Joint Commission and Health Equity

The Joint Commission has recently added “Health Equity Initiatives” as a national patient safety goal, which requires that all organizations have the following in place:

1. Identify an individual to lead activities to improve health care equity.
2. **Assess patients’ health-related social needs.**
3. Analyze quality and safety data to identify disparities.
4. **Develop an action plan to improve health care equity.**
5. Act when the organization does not meet the goals in its action plan.
6. Inform key stakeholders about progress to improve health care equity.

# Community Resource Directory

- findhelp (formerly known as Aunt Bertha)
  - Which version aligns best with Parkview's needs?
    - Navigation with our legal team
    - Integration with Epic
      - Ease of use for end-user
      - Visibility of follow-up/resources provided
  - Accessibility (patient/public)
    - Panel card
    - Parkview.com
    - MyChart
    - Translate function



# Looking Ahead...Growth & Sustainability

- Ongoing program evaluation and monitoring
- Referral/navigation opportunities
  - Streamlined method of identifying internal resources/follow-up workflows
  - Enhancement of staff training/education and demos
- findhelp
  - Interoperability with CBO's
    - Leveraging closed loop referrals
  - Community Engagement for a more robust network of CBO's
  - Documenting interventions within the HER
- Data capture and analysis
  - Consistent definitions and reporting
    - Data dictionary
  - Dashboards



# Pillars for Success

- Collaboration
- Understanding of current community needs
- Standardize where/when possible
- Leveraging of EMR functionality
- Education



# Questions?



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