Social Determinants of Health –
a Kaiser Permanente Perspective

eHI Roundtable on Social Determinants of Health – December 4, 2018

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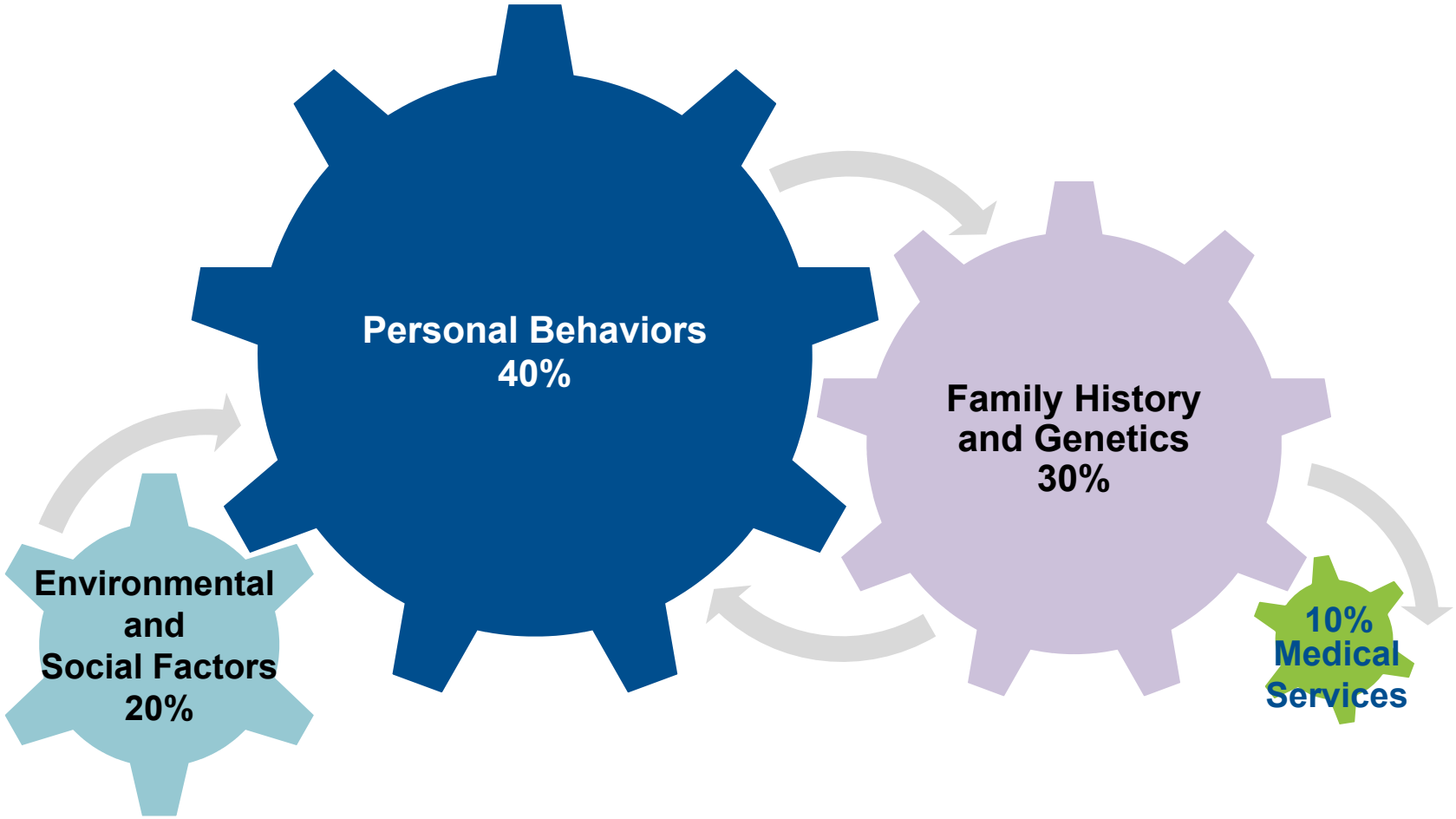
Key Concepts

- Definitions
  - WHO defines SDOH as "… conditions in which people are born, grow, live, work, and age…"
  - CDC defines *Determinants of Health* as "… factors that contribute to a person's current state of health…"; Social Determinants of Health are "… the complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities…such"
- Social… Determinants… Health
  - Social: Social environment, physical environment, health services, structural and societal factors…
  - Determinants: Contributors to? responsible for?
  - Health: Comprehensive, holistic view vs disease, episodic, conditions`
- Dimensions
  - WHO: Income, Education, Employment, Early childhood development, Food, Housing, Transportation, Social Safety Network, Health Services, Addiction, Gender, Race, Disability
  - Other: Housing; Utility and Technology; Nutrition; Benefits; Legal and Criminal Justice, Human Development, Social and Community Connections, Personal Hygiene, Activities of Daily Living, Safety and Disaster

Determinants of Health

…health care services is only a small component



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Sources of SDOH

- Health Plan
  - Enrollment information: capturing some of the social determinants from members
  - Expanding through access to external, context-specific data sources (public health, census, other)
- Provider
  - Data collected during clinical care and health services and maintained in EHR
  - Expanded through research from primary and secondary data collection
- Other
  - Individual vs Population data
  - Public health data
  - Community resources (social service networks, safety net providers)
  - Consumer data
  - Specialty data – Housing, Education, Transportation, Employment, Utility, Legal, Safety and Disaster, other

Uses of SDOH

- Individual Care
  - Personalized health (precision medicine)
  - Support delivery of services at point of care
  - Partnering and connecting with social service resources
- Population Health Management
  - Identification of populations at risk
  - Predictive analytics to support population health interventions
  - “Precision Population Health”
- Community Development
  - Social Service Resource Locator
  - Identification of gaps in SDOH at the community level
  - Implementation of strategies to fulfill gaps

Kaiser Permanente Partners With Communities to Achieve Total Health

October 25, 2016

Communities to Achieve Total Health will support six California communities as they began a three-year journey to improve the health of their residents.

In order to continue to innovate on improving the health of our members and communities, Kaiser Permanente has pursued strategies that recognize that health is shaped by powerful social and economic forces and community conditions, the “social determinants of health,” and that we must use all of our assets and resources to influence those factors.

With this view in mind, Kaiser Permanente is supporting the California Accountable Communities for Health Initiative (CACHI), which formally launches this week. In partnership with the California Endowment, the Blue Shield of California Foundation, and the state of California’s Health and Human Services Agency, through CACHI Kaiser Permanente will support six California communities as they began a three-year journey to improve the health of their residents. Kaiser Permanente is both a co-designer and co-funder of the initiative, as well as a participant in local collaboratives.

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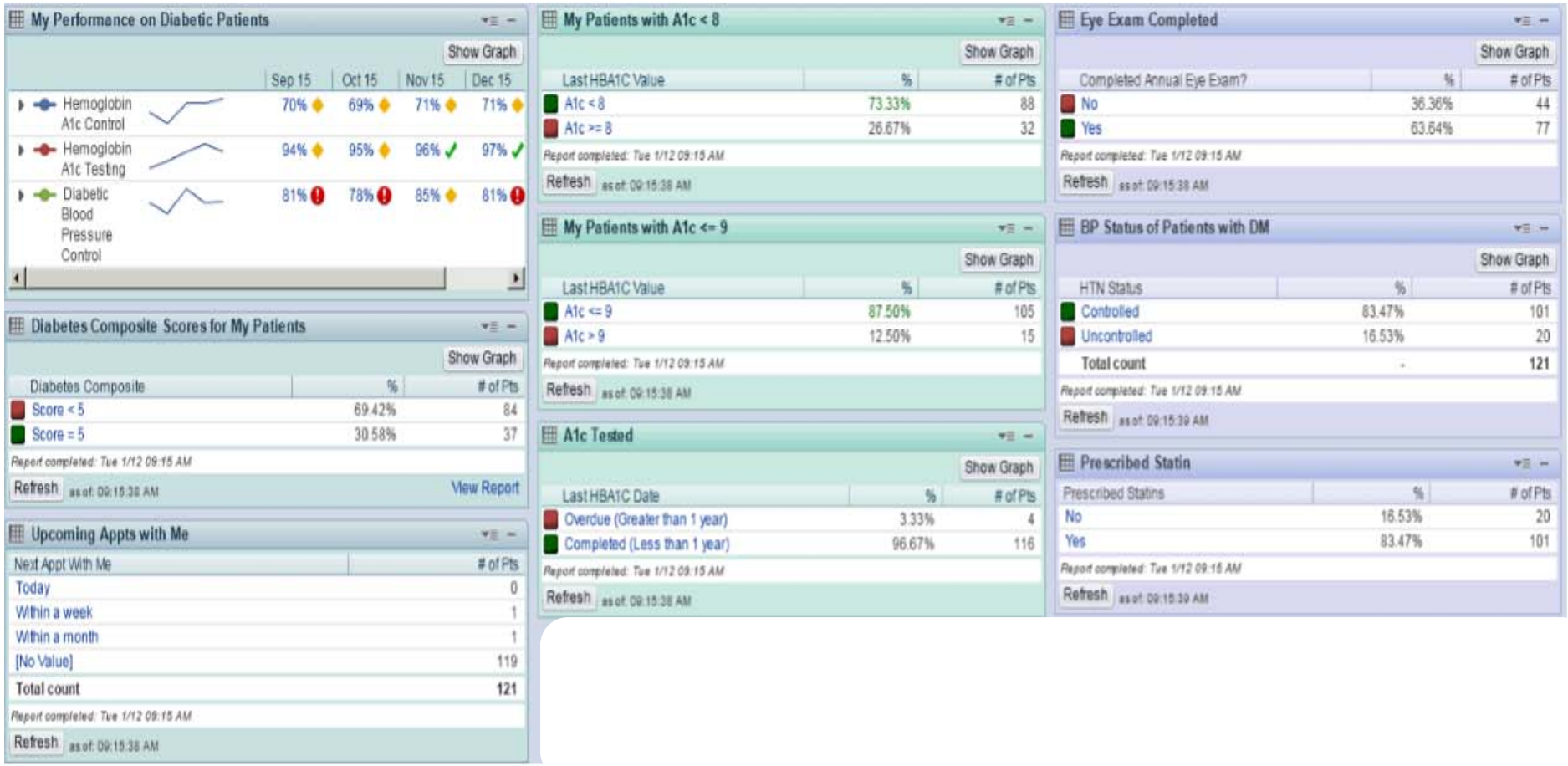
REAL TIME REPORTING

KPHC Dashboard: 24/7 Metric Reporting



My Performance on Diabetic Patients

Show Graph

	Sep 15	Oct 15	Nov 15	Dec 15
Hemoglobin A1c Control	70%	69%	71%	71%
Hemoglobin A1c Testing	94%	95%	96%	97%
Diabetic Blood Pressure Control	81%	78%	85%	81%

Diabetes Composite Scores for My Patients

Show Graph

Diabetes Composite	%	# of Pts
Score < 5	69.42%	84
Score = 5	30.58%	37

Report completed: Tue 1/12 09:15 AM

Refresh as of: 09:15:38 AM View Report

Upcoming Appts with Me

Next Appt With Me	# of Pts
Today	0
Within a week	1
Within a month	1
[No Value]	119
Total count	121

Report completed: Tue 1/12 09:15 AM

Refresh as of: 09:15:38 AM

My Patients with A1c < 8

Show Graph

Last HBA1C Value	%	# of Pts
A1c < 8	73.33%	88
A1c >= 8	26.67%	32

Report completed: Tue 1/12 09:15 AM

Refresh as of: 09:15:38 AM

My Patients with A1c <= 9

Show Graph

Last HBA1C Value	%	# of Pts
A1c <= 9	87.50%	105
A1c > 9	12.50%	15

Report completed: Tue 1/12 09:15 AM

Refresh as of: 09:15:38 AM

A1c Tested

Show Graph

Last HBA1C Date	%	# of Pts
Overdue (Greater than 1 year)	3.33%	4
Completed (Less than 1 year)	96.67%	116

Report completed: Tue 1/12 09:15 AM

Refresh as of: 09:15:38 AM

Eye Exam Completed

Show Graph

Completed Annual Eye Exam?	%	# of Pts
No	36.36%	44
Yes	63.64%	77

Report completed: Tue 1/12 09:15 AM

Refresh as of: 09:15:38 AM

BP Status of Patients with DM

Show Graph

HTN Status	%	# of Pts
Controlled	83.47%	101
Uncontrolled	16.53%	20
Total count	-	121

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Refresh as of: 09:15:39 AM

Prescribed Statin

Prescribed Statins	%	# of Pts
No	16.53%	20
Yes	83.47%	101

Report completed: Tue 1/12 09:15 AM

Refresh as of: 09:15:39 AM

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Tools for Using SDOH Data

- Screening Instruments
  - National Association of Community Health Centers' Protocol for Responding to and Assessing Patients' Risks, and Experiences – PREPARE Tool
  - American Academy of Family Physicians EveryONE Project Screening Tools (long- and short-term form)
  - CMS Accountable Health Communities' Health-Related Social Needs Screening Tool
- Population Health Analytics
  - NQF Social Determinants of Health Data Integration Initiative – to integrate SDOH into clinical practice
  - Risk assessment tools integrated to EHRs and Health Plan Data Systems
  - Advanced predictive analytics tools to identify populations and individuals that may suffer from specific deterioration of health situations
- Toolkits
  - Association of Academic Health Centers developed a Toolkit to Promote Multi-Sectorial Collaboration to address SDOH

Standards for SDOH

- Major challenges exist regarding the definition of standards for the collection, use and exchange of SDOH data
- Lack of basic consistent definitions across the industry on SDOH domains, and metrics related to those domains
- Need for identifying and establishing harmonized SDOH value sets, terminologies, vocabularies and code sets
- Need to incorporate standardized SDOH data elements into EHR systems, health plan data systems, public health databases
- Important standards development efforts underway
  - Institute of Medicine recommended inclusion of 12 SDOH in all EHRs
  - ONC Interoperability Standards Advisory identifies initial set of SDOH data elements, including financial resources, education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence
  - SIREN – Social Intervention Research and Evaluation Network: developing a series of harmonized value sets on SDOH
  - NCVHS – Measurement Framework for Community Health and Well Being
  - CDC Social Determinants of Health Initiative
  - HL7 FHIR-based bi-directional services e-referral for EHR – Social Service communication