Starfield Summit II: Health Equity Summit
Curriculum Toolkit

Community Vital Signs: Achieving Equity through Primary Care Means Checking More than Blood Pressure

IGNITE presentation by Andrew Bazemore, MD, MPH

Module by Tiffany Covas, MD, MPH, Jordan Brown, MS, Jane Weida, MD, and Jennifer Edgoose, MD, MPH

Appropriate Audience: All learners

Related Modules:

- Identifying and Addressing Patients' Social and Economic Needs in the Context of Clinical Care
- Understanding Health Experiences and Values to Address Social Determinants of Health.
- Intersectionality – The Interconnectedness of Class, Gender, Race, and other Types of Vulnerability.

Learning Objectives

After participating in this learning module, the participant will be able to:

1. Recognize the role that primary care has in operationalizing a framework to implement social determinants of health into the delivery of care.
2. Describe Community Vital Signs and appreciate how their incorporation into the electronic health record can promote more equitable outcomes for patients and panels.
3. Understand how Community Vital Signs build upon the model of community-oriented primary care.

Background

Social determinants of health (SDoH) -- the conditions where we live, learn, work, and play-- are widely recognized as critical factors driving health outcomes. Early analysis demonstrated SDoH accounted for 20% of health outcome[1,2] while more recent models such as County Health Rankings place this figure at 40%.[3] In contrast, clinical services and access to these services may account for only 10-20% of health outcomes.[1,2,3] Clinicians providing frontline primary care to vulnerable populations are well aware of the impact of SDoH but rarely have the training and tools to address these social determinants for the patients and populations they serve. In a time of publicly available health information data, geospatial technology, and patient portals allowing for privately input data, there now exists enormous opportunity to complement biometric data in the electronic health record (EHR) with community vital signs (VS) which provide an aggregated community-level overview of the social and environmental factors impacting patient health.[2]

In the 1940s Sidney and Emily Kark opened the Pholela Community Health Centre on a rural, poor tribal reserve of South Africa and began to develop new approaches to care coining the term"community-oriented primary care (COPC)." They recognized that the most effective way to address health was not through acute medical care of individuals but rather through a population-level approach that integrated public health and primary care.[3] These principles were brought to the first federally-funded community health center in the United States by H. Jack Geiger in 1957. Now over sixty years later with the democratization of big data and opportunities to promote inclusion of Community VS into the EHR, we may find ourselves on the cusp of fully actuating the principles at the heart of COPC and advancing primary care's role in achieving health equity for our patients and communities.

Ignite Video

Please follow the link below to view the full talk given by Andrew Bazemore, MD, MPH (~9min):
https://www.youtube.com/watch?v=1ch-7Gqhuig

Accompanying Slides

https://static1.squarespace.com/static/56bb9997746fb9d2b5c70970/t/594a82d9bebafb954cc19662/1498055395958/3.3+Bazemore_CVSigns_Starfield+II.pdf

Questions for Group Discussion

After watching the talk, consider splitting your learners into smaller groups and facilitate discussion on the following questions:

1. Name at least three examples of social and behavioral domains that comprise Community VS?
2. What kind of publicly available small area level data (e.g. census tract level data) are available that could be used to measure SDoH?
3. Which SDoH data do you think are most feasible to capture for use in a clinical setting?
4. Which SDoH data do you think are most meaningful to clinicians and office administrators trying to improve health for their patients and community?
5. SDoH are bound-up in place affecting personal and community-level outcomes. What does Jack Westfall mean when he describes "cold spots" compared to "hot spots"? (Refer to "*Westfall JM. Cold-spotting*" in "For more in-depth discussion, read and refer to" section)
6. What data must be collected from patients in order to be meaningful? What area information is important but could be captured and appended to patient records administratively? What are the limitations and strengths of each (accuracy, relevance to health, administrative burden, privacy concerns, etc.)?
7. How do we build the evidence base and implementation science knowledge to effectively address SDoH via primary care?
8. How should application of Community VS be accounted for in new payment models and value-based reimbursements to primary care?

Applying an Equity Lens in Professional Practice

As you reflect on the material in this module consider how you will apply it in your professional practice by asking questions based upon the Equity and Empowerment Lens' 5Ps:

PURPOSE: While it is clear that we need to better address SDoH in primary care, propose a specific intervention that will promote incorporation of Community VS into clinical practice.
PEOPLE: Which people are positively and negatively affected by your proposal? Consider patients but also consider the healthcare workforce.
PLACE: How does the integration of your proposal contribute to patients' emotional and physical safety and their need to be productive and feel valued?
PROCESS: How are we including vulnerable communities to participate in design of this intervention?
POWER: How can we ensure that the priorities and concerns of all stakeholders are being appropriately met?

For more in-depth discussion read and refer to:

- Bazemore AW, Cottrell EK, Gold R, Hughes LS, Phillips RL, Angier H, Burdick TE, Carrossa, MA, DeVoe JE. "Community Vital Signs": Incorporating geocoded social determinants into electronic records to promote patient and population health. J Am Med Inform Assoc. 2015 Jul13. Pii:ocv088. https://www.ncbi.nlm.nih.gov/pubmed/26174867. Accessed May 15, 2018.
    - This article details the importance of incorporating community-level SDoH into EHRs to enable physicians and practices to track social and environmental factors which impact patient health. Such data can help target disease prevention and health promotion efforts.

- DeVoe JE, Bazemore AW, Cottrell EK, et al. Perspectives in primary care: A conceptual framework and path for integrating social determinants of health into primary care practice. *Ann Fam Med.* 2016;14(2):104-108. http://www.annfammed.org/content/14/2/104.full.pdf+html. Accessed May 15, 2018.
    - This article emphasizes the impact of SDoH outcomes, and it suggests a framework to integrate SDoH into primary care.

- Institute of Medicine. Summary in:*Capturing Social and Behavioral Domains and Measures in Electronic Health Records: Phase 2.* Washington, DC: The National Academies Press; 2014. https://www.nap.edu/download/18951.

Accessed May 15, 2018.
    - Healthcare systems have traditionally focused on treatment of disease of individual patients rather than social determinants of health. Many pressures are increasing the need for health care systems individual clinicians to focus on social and behavioral determinants of health. This IOM report details a study to identify social and behavioral determinants of health for inclusion in electronic health records.

- Westfall JM. Cold-spotting: Linking primary care and public health to create communities of solution. *J Am Board Fam Med* 2013;26:239-40. http://www.jabfm.org/content/26/3/239.long. Accessed May 15, 2018.
    - This article introduces the concept of "cold-spotting." Hot-spotting was a concept developed by Dr. Jeffrey Brenner to identify those very high-cost patients who are super-utilizers of the health care system. Cold spots describe the communities in which hot-spotters often live and may be described as environments lacking the "warmth of social support." Cold-spotting is, thus, identification of areas in the community that do not provide essentials for health such as safety, grocery stores, good air quality air, etc. Providing these essentials may eliminate both cold spots and hot spots of high utilization.

Resources for further exploration:

Macro: In Health Care Transformation

- National Quality Forum. Multi-stakeholder input on a national priority: improving population health by working with communities – Action guide 1.0. Washington, DC: National Quality Forum; 2014.
    - This article discusses the importance of focusing on population health as a means to narrow the gap in health disparities and serves as a guide to provide recommendations to build or refine population health initiatives. Collectively, this guide takes a broad look at issues and provides action recommendations to improve population health at the local, state, regional, and national levels.

Meso: In Quality Improvement

- Hughes LS, Phillips RL, DeVoe JE, Bazemore AW. Community vital signs: Taking the pulse of the community while caring for patients. *J Am Board Fam Med* 2016;29(3):419-422. http://www.jabfm.org/content/29/3/419.full.pdf+html Accessed May 16, 2018.
    - In reviewing the Institute of Medicine's and the National Quality Forum's recommendations that social determinants be collected in EHRs, the authors propose a more reliable, less burdensome way to acquire this information using community-level geospatial information and linking them to patients' EHRs so that primary care practices can understand the context of where patients live.

- DeVoe JE, Gold R, Cottrell E, et al. The ADVANCE network: Accelerating data value across a national community health center network. *J Am Med Inform Assoc* 2014;21:591–5. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4078289/pdf/amiajnl-2014-002744.pdf Accessed May 16, 2018.
    - This article describes a network providing horizontal and vertical integration of outpatient EHR data between federally qualified health center, hospital, health plan and community data for these patients who are often underrepresented in research. This data will help create a research infrastructure for determining patient-centered outcomes for disadvantaged and vulnerable populations.

Micro: In Clinical Encounters- Shared Decision Making

- Andermann A. Taking action on the social determinants of health in clinical practice: a framework for health professionals. *CMAJ : Canadian Medical Association Journal*. 2016;188(17-18):E474-E483. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5135524/pdf/188e474.pdf. Accessed May 16, 2018.
    - This review article provides examples of how SDoH can be addressed at a patient, practice and community level. It also outlines common barriers as well as facilitators and other evidence-based resources and guidelines to overcome these barriers.

- A new way to talk about the social determinants for health. Vulnerable Populations Portfolio. Princeton, NJ: Robert Wood Johnson Foundation;2010. https://societyforhealthpsychology.org/wp-content/uploads/2016/08/rwjf63023.pdf. Accessed May 16, 2018
    - Although SDoH are well-established in academia, it was found that the description was confusing and often the meaning was misinterpreted in practice. In this article, the Robert Wood Johnson Foundation incorporates ways to reframe the discussion of SDoH that makes it easier for people to understand and relate to. By doing so, it has led to more effective discussions that can expand American's views and perceptions of SDoH and what it means to be healthy.

Words and Concepts Used in this Module that are Defined in the Guidebook

- Community Vital Signs
- Electronic Health Record
- Geocoded Data
- Health Equity
- Population Health
- Social Determinants of Health

References

1. Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual causes of death in the United States, 2000. *JAMA.* 2004;291(10):1238-1245.
2. McGinnis JM, Foege WH. Actual causes of death in the United States. *JAMA.* 1993;270(18):2207–2212.
3. County Health Rankings Model. Madison, WI: University of Wisconsin Population Health Institute;2014 http://www.countyhealthrankings.org/explore-health-rankings/what-and-why-we-rank. Accessed May 15, 2018.
4. Hughes LS, Phillips RL, DeVoe JE, Bazemore AW. Community vital signs: Taking the pulse of the community while caring for patients. *J Am Board Fam Med* 2016;29(3):419-422.
5. Liaw W, Rankin J, Bazemore A, Ventres W. Teaching population health: Community-oriented primary care revisited. *Acad* Med 92(3): 419.

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Module Writers

Tiffany Lynn Covas, MD, MPH
Duke University
Duke Family Medicine Center
Durham, NC

Jordan L. Brown, MS
Duke University School of Medicine
Durham, NC

Jane A. Weida, MD, MS
University of Alabama College of Community Health Sciences
Tuscaloosa, AL

Jennifer Edgoose, MD, MPH
University of Wisconsin – Madison
School of Medicine and Public Health
Department of Family Medicine and Community Health
Madison, WI