COMMUNITY VITAL SIGNS: ACHIEVING EQUITY THROUGH PRIMARY CARE MEANS CHECKING MORE THAN BLOOD PRESSURE
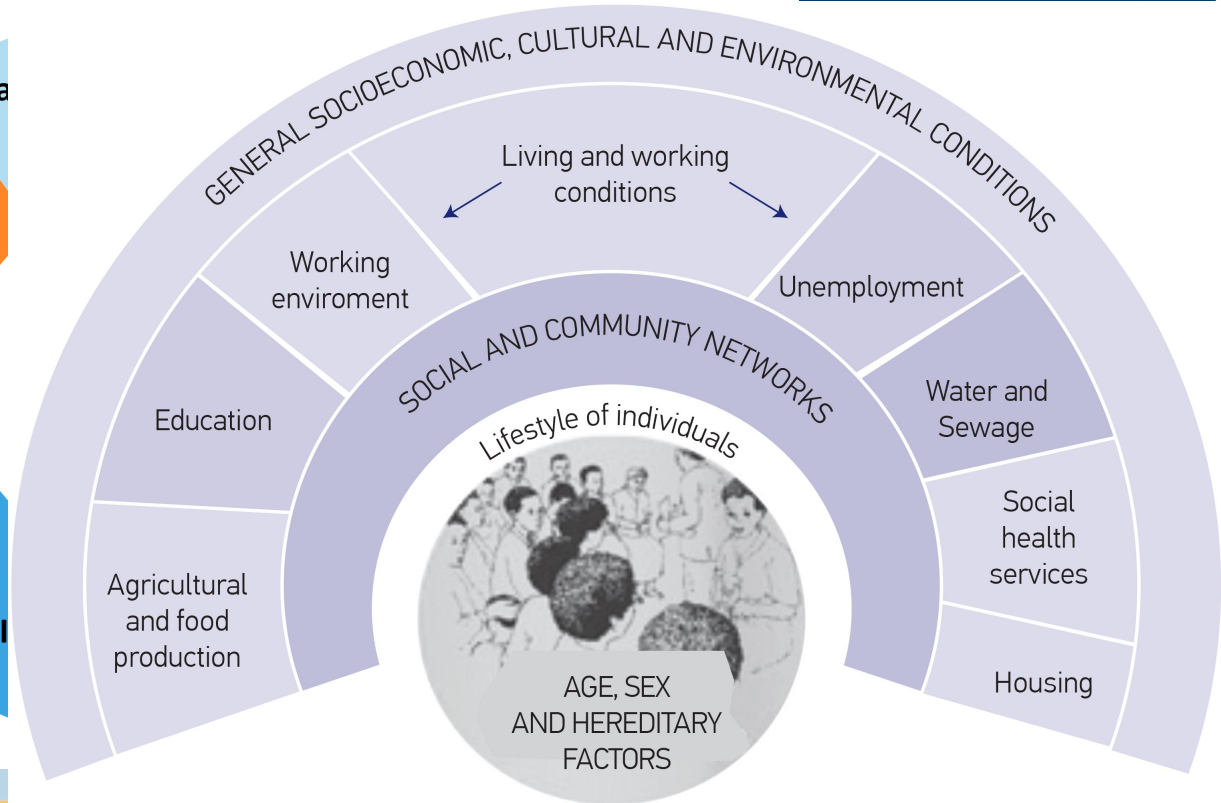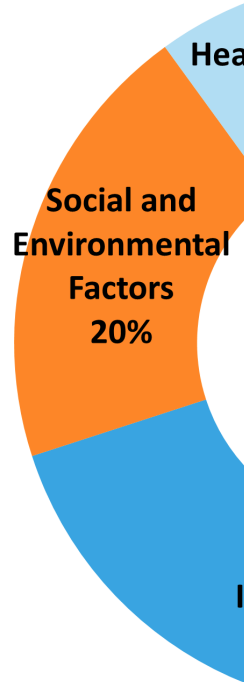
Andrew Bazemore
Director

Robert Graham Center for Policy Studies
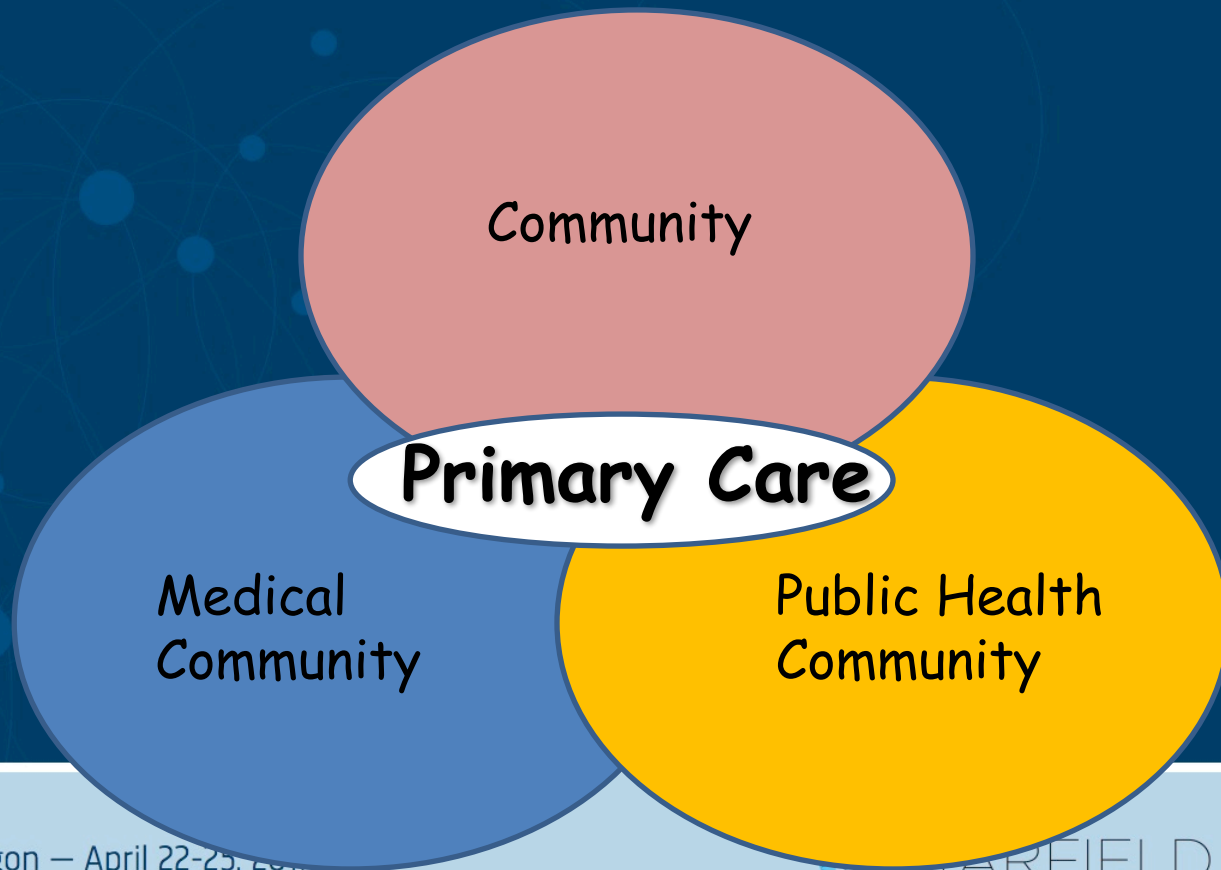
Portland, Oregon — April 22-25, 2017

STARFIELD SUMMIT

Impact of Different Factors on Risk of Premature Death

Community

Primary Care

Medical Community

Public Health Community

Portland, Oregon — April 22-23, 20__

STARFIELD SUMMIT

Drs. Sidney and Emily Kark early 1940s

Pholela Health Center, South Africa
Community Oriented Primary Care

STARFIELD SUMMIT

Tufts-Delta Health Center Mound Bayou, MS

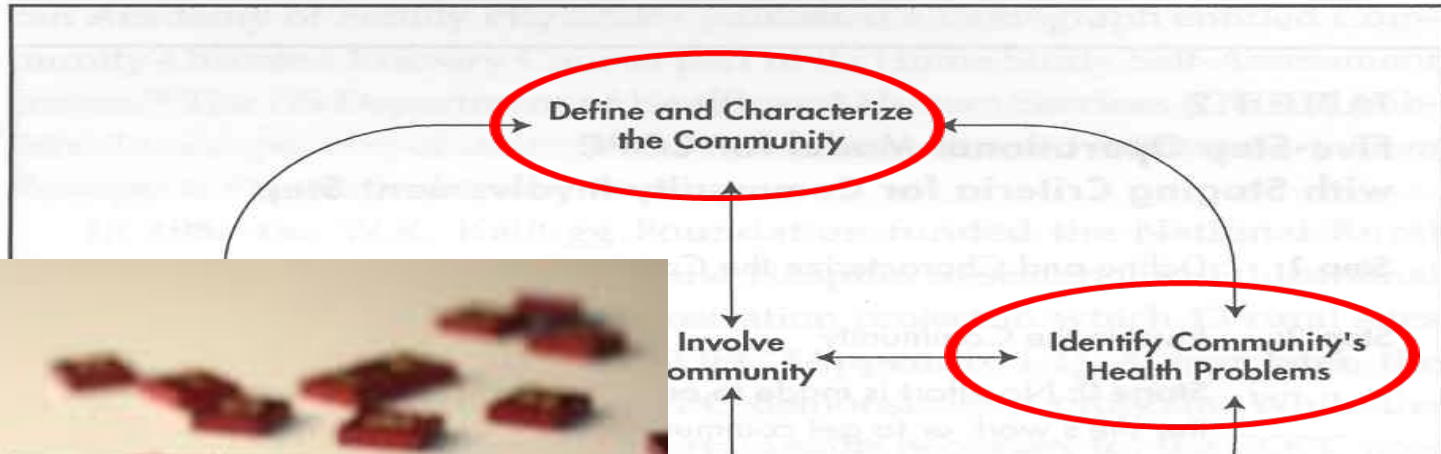http://apps.nlm.nih.gov/againsttheodds/exhibit/community_health/common_ground.cfm

STARFIELD SUMMIT

FIGURE 1.2: The COPC Process

Define and Characterize the Community

Involve Community

Identify Community's Health Problems

JEALOUSY

I do not like the cone of shame.

Table 2: Indicator... ...S Type

Data Source
American Community Survey
US Census Bureau, county business patterns
US Census Bureau, ZIP code business patterns
American Community Survey
Center for Disease Control and Prevention (CDC), Environmental Public Health Tracking Network
Environmental Protection Agency, Safe Drinking Water Information System
Agency for Toxic Substances and Disease Registry
American Community Survey
Department of Housing and Urban Development, Neighborhood Stabilization Program
American Community Survey
Center for Disease Control and Prevention, Environmental Public Health Tracking Network
US Census Bureau, county business patterns
US Census Bureau, ZIP code business patterns
USDA Food Access Research...

...y (all food stores); percent of people in a county living more than 1 mile from a supermarket or large grocery store if in an urban area, or more than 10 miles if in a rural area; percentage of population living within ½ mile of a park, recreation faciliti...

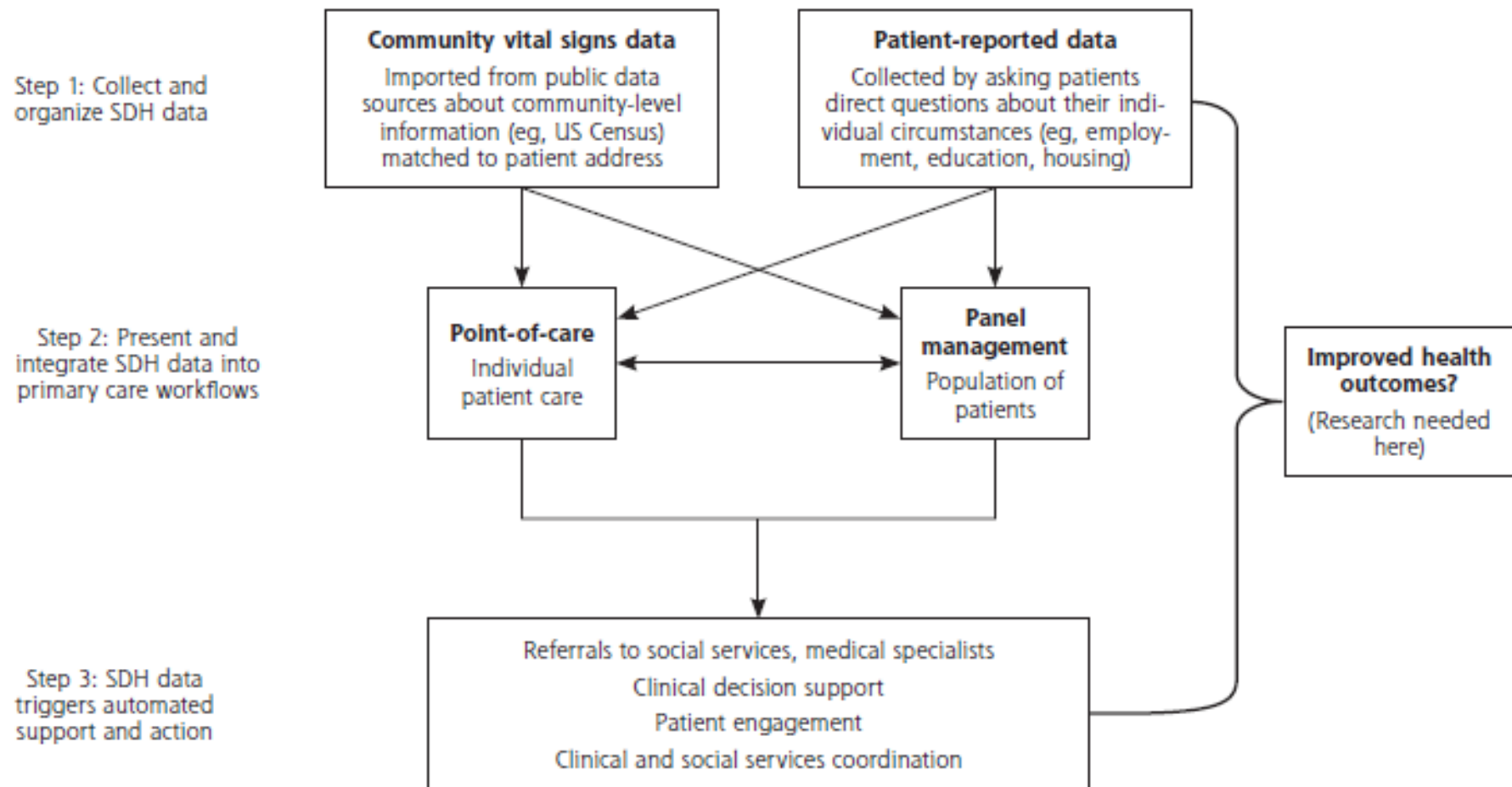Capturing Social and Behavioral Domains and Measures in Electronic Health Records

PHASE 2

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

Portland, Oregon — Ap

⚙ STARFIELD SUMMIT

Figure 1. A framework for integrating social determinants of health (SDH) into primary care.

Step 1: Collect and organize SDH data

Community vital signs data
Imported from public data sources about community-level information (eg, US Census) matched to patient address

Patient-reported data
Collected by asking patients direct questions about their individual circumstances (eg, employment, education, housing)

Step 2: Present and integrate SDH data into primary care workflows

Point-of-care
Individual patient care

Panel management
Population of patients

Improved health outcomes?
(Research needed here)

Step 3: SDH data triggers automated support and action

Referrals to social services, medical specialists
Clinical decision support
Patient engagement
Clinical and social services coordination

Patient Centred Assessment Method (PCAM)

Vs2.0 February 2015

ID _____

_____

Date: _ _/ _ _ _ _/2 0 _ _

Nurse/Clinician: _____

Instructions: Use this assessment as a guide, ask questions in your own words during the consultation to help you answer each question. Circle one option in each section to reflect the level of complexity relating to this client. To be completed either during or after the consultation.

Health and Well-being

1. Thinking about your client's **physical health needs**, are there any symptoms or problems (risk indicators) you are unsure about that require further **investigation**?			
No identified areas of uncertainty or problems already being investigated	Mild vague physical symptoms or problems; but do not impact on daily life or are not of concern to client	Mod to severe symptoms or problems that impact on daily life	Severe symptoms or problems that cause significant impact on daily life
2. Are the client's **physical health problems** impacting on their **mental well-being**?			
No identified areas of concern	Mild impact on mental well-being e.g. "feeling fed-up", "reduced enjoyment"	Moderate to severe impact upon mental well-being and preventing enjoyment of usual activities	Severe impact upon mental well-being and preventing engagement with usual activities
3. Are there any problems with your client's **lifestyle behaviors** (alcohol, drugs, diet...			
No identified areas of...			

Or us
SDH?

Table 2: Indicators selected for ADVANCE Pilot by Community VS Type		
Community VS	Indicators	Data Source
Built environment	Fast food restaurants per 100 000 population; liquor stores per 100 000 population; population density	American Community Survey

"Community Vital Signs": Incorporating geocoded social determinants into electronic records to promote patient and population health

Andrew W Bazemore[1], Erika K Cottrell[2,3], Rachel Gold[2,4], Lauren S Hughes[5], Robert L Phillips[6], Heather Angier[3], Timothy E Burdick[3,7], Mark A Carrozza[8], Jennifer E DeVoe[2,3]

ABSTRACT

Social determinants of health significantly impact morbidity and mortality; however, physicians lack ready access to this information in patient care and population management. Just as traditional vital signs give providers a biometric assessment of any patient, "community vital signs" (Community VS) can provide an aggregated overview of the social and environmental factors impacting patient health. Knowing Community VS could inform clinical recommendations for individual patients, facilitate referrals to community resources, and improve understanding of factors impacting treatment adherence and health outcomes. This information could also support efforts for clinic panels and populations. Given
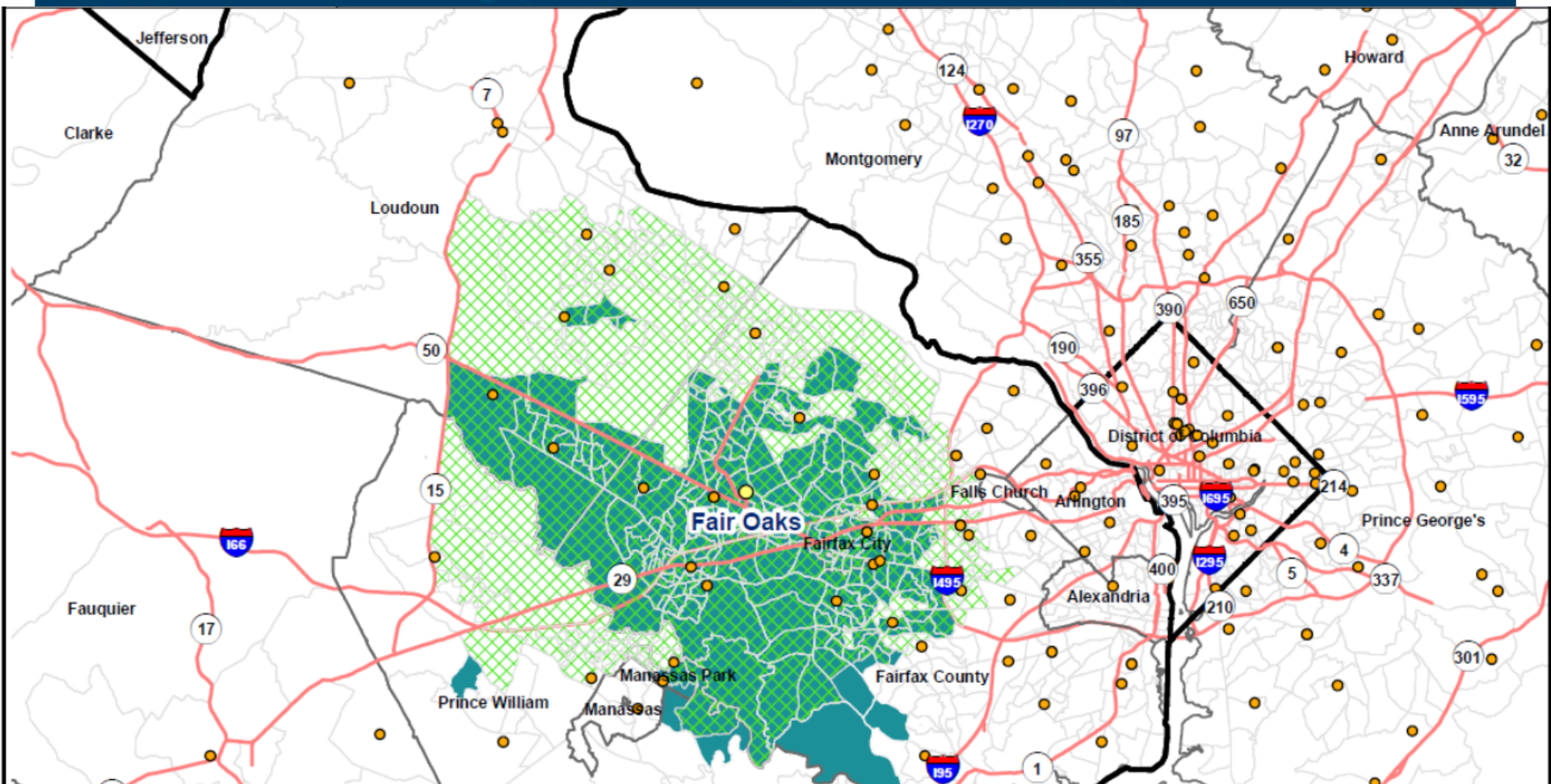
Making SDH data easier to digest for the provider?

Table 3.4: Low Resource Deficit, Low Community Deficit				
Social Disadvantage Index	H			
	M			
	L			
		L	M	H
		Neighborhood Disadvantage Index		

Ripple of Hope: Redux

"If you think you are too small to be effective, you have never been in bed with a mosquito"

STARFIELD SUMMIT