

# Houston Methodist

## Social Determinants of Health Wheel FAQ

### Commitment to Addressing Social Determinants of Health:

Houston Methodist established the Health Equity Steering Committee with the objective to uphold the Houston Methodist standard of unparalleled, personalized care and service through fair treatment, access and opportunity for health care and health improvement for all patients. The committee strives to identify and eliminate barriers to health optimization for all populations served, such as addressing social determinants of health. Houston Methodist aims to improve how the health care system collects this information through the utilization of Epic's Social Determinants of Health Wheel. The success of understanding the patient population is contingent upon all employees doing their part to increase utilization of this Epic feature so Houston Methodist may begin the work of creating access to necessary resources that will help lead to better health outcomes for its patients.

Q: What is Healthy Equity?

A: Health equity means everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health (social determinants of health) such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments and health care.

Q: What are Social Determinants of Health (SDOH)?

A: Social determinants of health are the social and economic conditions in which people are born, live, work and play. Examples of social determinants of health can include, but are not limited to factors such as race, ethnicity, gender, sexual orientation and language which can all correlate to social determinants related to a person's ability to afford or access health care, access healthy food, access affordable housing, access transportation and more. SDOH are often the underlying drivers of major health issues such as diabetes, obesity, depression and heart disease.

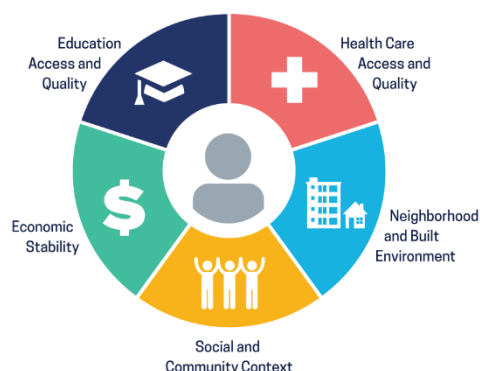
Q: What is the SDOH Wheel?

A: The SDOH Wheel is located within Epic and allows health care systems to document social, behavioral, and economic information on patients. The wheel is comprised of 12 domains which cover a variety of SDOH such as housing status, social support and more. Within each domain are a set of screening questions designed to help clinical teams understand what social and economic factors may be impacting a patient outside of the health care setting which can have implications on a person's ability to adhere to a care plan.

Q: Where is the SDOH Wheel located in Epic?

A: The SDOH Wheel can be found in different locations within Epic. Most employees can find it under the "History" tab. However, it can also be located on the patient's storyboard. Any Epic user with the ability to document within "History" can access the screening questions. (See screenshots 1 and 2.)

### Social Determinants of Health



Q: What are the current 12 domains in the screening questions?

A: - Alcohol Use  
- Depression  
- Financial Resource Strain  
- Food Insecurity  
- Housing Stability  
- Intimate Partner Violence  
- Physical Activity  
- Prescription Affordability (New)  
- Postpartum Depression  
- Social Connections  
- Stress  
- Tobacco Use  
- Transportation Needs

Q: Are we expected to address all 12 domains and ask all the screening questions?

A: No. This is a phased approach to better understand the state of the patient population. Therefore, Houston Methodist is initially prioritizing the identification of the following SDOH domains: Food Insecurity; Social Connections; Transportation Needs; Prescription Affordability; Depression; Alcohol Use and Tobacco Use

Q: How does the SDOH Wheel get filled in?

A: Answering the screening questions based on the patient's response will automatically populate the SDOH Wheel. A person's risk level for a certain SDOH will appear in the wheel and will also be illustrated by a small icon highlighted on the storyboard. (See screenshots 3 and 4.)

Q: Why is the SDOH link being added to the patient's storyboard?

A: The link to the SDOH Wheel is being added to the patient's storyboard to allow easier access for clinical teams to see when a patient is high risk for a SDOH and to make it easier to document an identified SDOH when the information is disclosed by a patient.

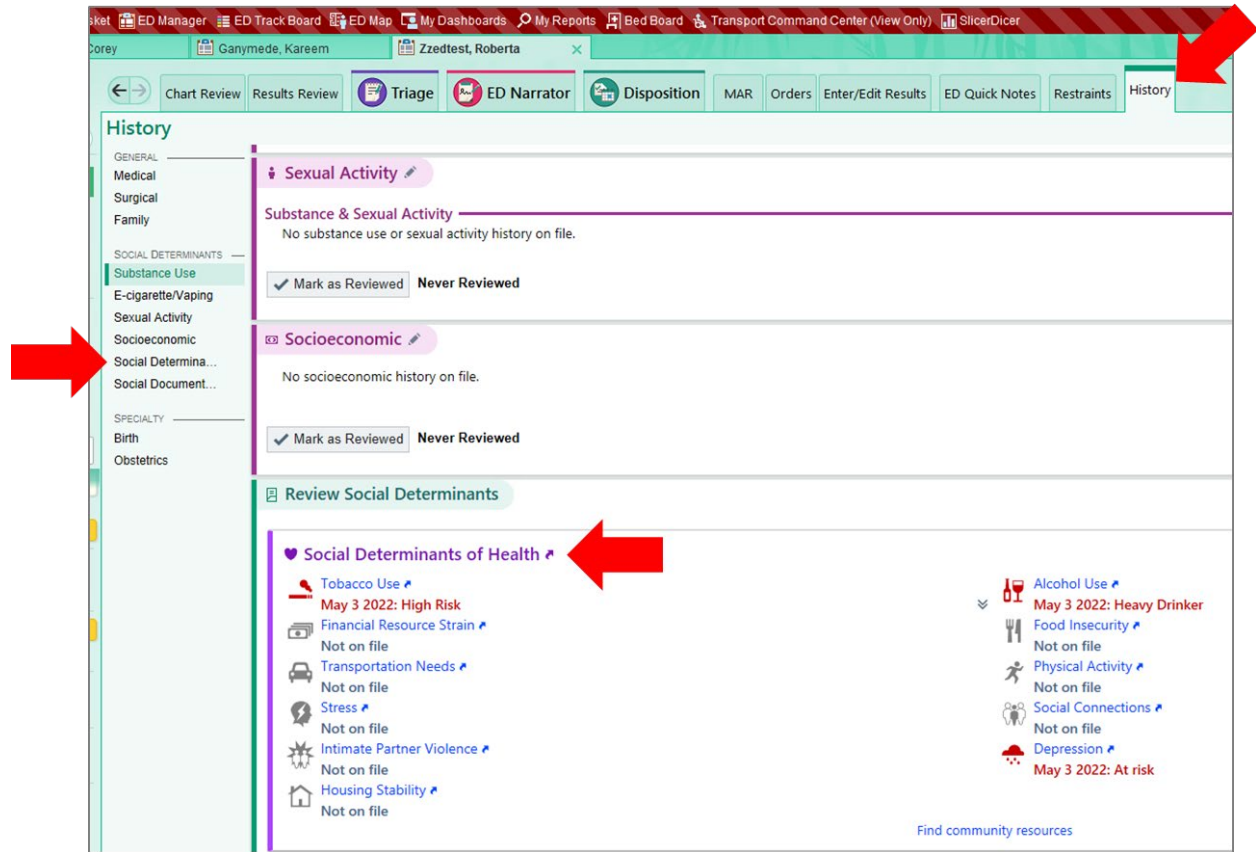
Q: By adding the SDOH link to the storyboard, what action as a physician do I need to take?

A: At this time, no additional action is being requested from the physician. Through the provider's standard workflow, if a patient discloses a SDOH impacting his/her ability to adhere to treatment, we encourage you to try to document it using the SDOH Wheel. However, Houston Methodist will also work to proactively capture this information within the patient population by utilizing eCheck-in and MyChart.

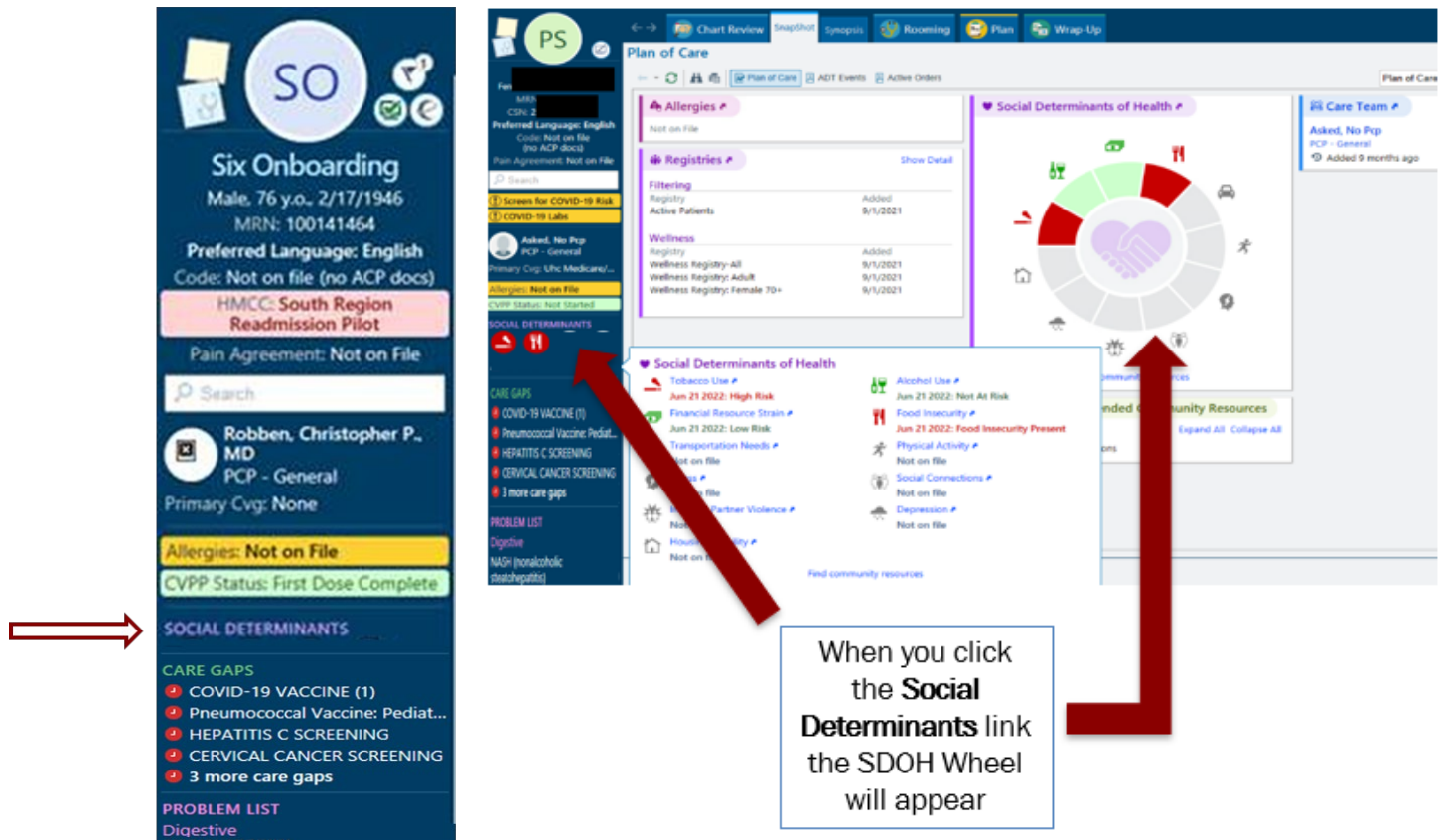
Q: My patient has been identified as being high risk for a social determinant of health. Now what?

A: As Houston Methodist learns more about the social and economic barriers within its patient population, it will help the health care system develop a strategic approach to addressing the identified challenges. There are some services currently available to assist patients with select SDOH such as transportation or food insecurity, within limits. If your patient has an identified SDOH that has been unaddressed and you feel it is impacting their ability to adhere to their care or treatment plan, please email [SDOH@houstonmethodist.org](mailto:SDOH@houstonmethodist.org) with the patient's MRN and the SDOH domain that you feel needs to be addressed.

### Screenshot 1: How to locate the SDOH Wheel from the "History" tab?



### Screenshot 2: How to locate the SDOH Wheel from the patient's storyboard?



**Screenshot 3: How a patient's risk level appears visually in the SDOH Wheel?**

**Review Social Determinants**

**Social Determinants of Health**

- Tobacco Use
  - Not on file
- Financial Resource Strain
  - Apr 21 2022: High Risk
- Transportation Needs
  - Apr 21 2022: Unmet Transportation Needs
- Stress
  - Apr 21 2022: Stress Concern Present
- Intimate Partner Violence
  - Apr 21 2022: Not At Risk
- Housing Stability
  - Apr 21 2022: High Risk
- Alcohol Use
  - Apr 21 2022: Heavy Drinker
- Food Insecurity
  - Apr 21 2022: Food Insecurity Present
- Physical Activity
  - Apr 21 2022: Insufficiently Active
- Social Connections
  - Apr 21 2022: Unknown
- Depression
  - Not on file

Find community resources



**Summary**

Infusion Orders  
No relevant orders to display.

**Social Determinants of Health**

As the SDOH Wheel is updated:

- Green - no to low risk
- Yellow - moderate risk
- Red - high risk
- Gray - no data

Find community resources

**Screenshot 4: How does a high risk SDOH appear on the storyboard?**

PG

Female,  
MRN:  
Preferred Language: English  
Code: Not on file (no ACP docs)  
Pain Agreement: Not on File  
NaRx Score : 250

Search

Screen for COVID-19 Risk  
COVID-19 Labs

Asked, No Pcp  
PCP - General  
Primary Cvg: Uhc Medicare/...

Allergies: Not on File  
CVPP Status: Not Started

**SOCIAL DETERMINANTS**

CARE GAPS

- COVID-19 VACCINE (1)
- Pneumococcal Vaccine: Pediat...
- HEPATITIS C SCREENING
- CERVICAL CANCER SCREENING
- 3 more care gaps

PROBLEM LIST

Digestive

Registries: [Wellness] Wellness  
Registry-All, Wellness  
Registry: Adult, Wellness  
Registry: Female 70+  
Insufficiently Active Patients

When you click on a specific domain, additional details will pop up

Food Insecurity

3/2018 Today

**MAR 3 2021 At Risk**

3. Over the last 6 months, have you worried about having enough money for food?  
**Yes**