Electronic Health Record (EHR) Instructions
for the Epic® EHR System

# Social Determinants of Health (SDoH) Guide

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# 01. Background and Limitations

This SDoH Guide was created specifically to leverage Epic's SDoH functionality to help health systems achieve improved immunization rates for appropriate patients treated by doctors using the Epic EHR system. The content herein will not work for other conditions, treatments, therapeutic areas, or on other EHR systems. The intent of this guide is to provide suggestions for leveraging Epic's SDoH suite of tools to drive immunization rates at the health system level.

This guide provides specific considerations for identifying patients with potential social equity gaps and provides appropriate solutions to help address social equity gaps in the Epic EHR system.

The processes outlined in this piece are variable, and not all steps will apply to every health system. Any steps or settings that are not part of a health system's standard process should be excluded or modified accordingly. Any questions should be directed to the appropriate service provider. The practice is solely responsible for the implementing, testing, monitoring, and ongoing operation of any EHR tools.

This guide is designed for organizations using the Epic 2023 version or later. Some configurations to the EHR system may be required by a clinical analyst.

# **02.** SDoH Overview

Leveraging Epic EHR tools that are relevant for SDoH requires structured documentation for each of the health equity factors to identify any SDoH care gaps. Sociodemographic factors, among others, are associated with increased vaccine uptake.[1,2]

Epic includes standard functionality for documenting a patient's SDoH. The SDoH domains in Epic include:

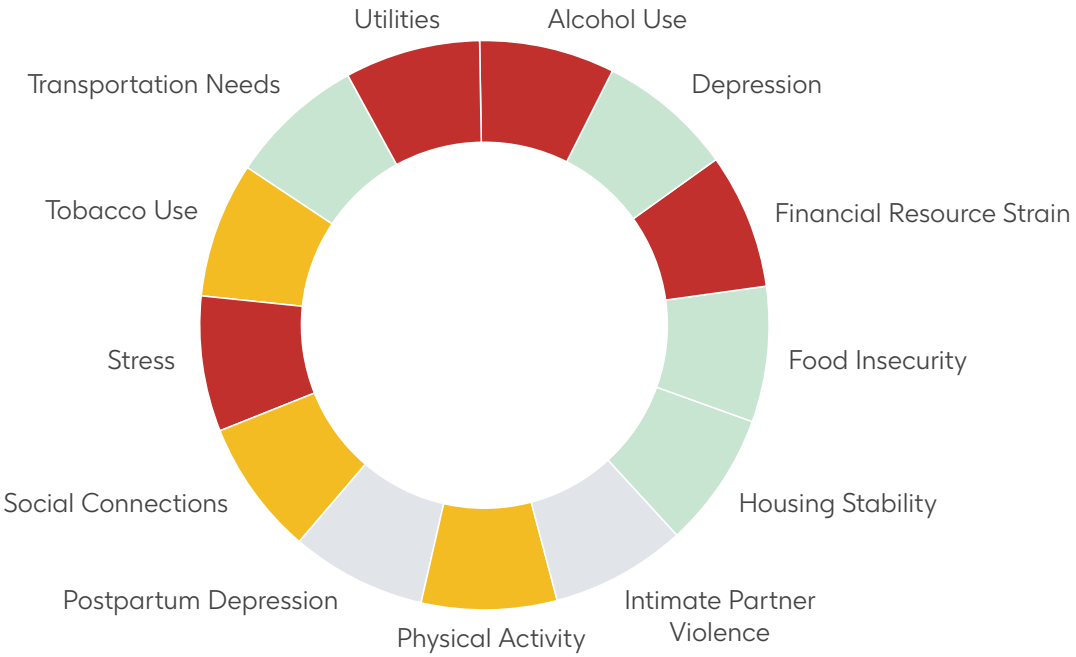
- Alcohol Use
- Depression
- Financial Resource Strain
- Food Insecurity
- Housing Stability
- Intimate Partner Violence
- Physical Activity
- Postpartum Depression
- Social Connections
- Stress
- Tobacco Use
- Transportation Needs
- Utilities

# 03. SDoH Documentation

A standard assessment or screening tool for SDoH is available in the Epic EHR system and can be completed by an HCP and/or patient. Two (2) options are available:

### Option 1: SDoH Flowsheet for HCPs

Flowsheets are commonly used to document vital signs, histories, lab results, and other clinical variables. In the Assessment Activity, the SDoH section allows for documenting SDoH domains by an HCP (nursing staff, community health nurse, social worker, or other care provider). After the information has been entered, it becomes available in a print group (a color-coded SDoH wheel) and can be displayed in Epic for other HCPs to view.




*Example of the SDoH Wheel*

Documenting the SDoH domains can be done by using flowsheets released by Epic or with specific history forms. As a best practice, review current documentation practices for SDoH data and confirm alignment with the established SDoH domains. For example, if a patient's results from a depression screening using the PHQ-9 is documented in the associated SmartForm, ensure all underlying SDoH connections have been set up to reflect in the print groups, any navigator activity, reports and other chart areas. Similarly, the AUDIT-C is a common option to document alcohol screening for the Substance Abuse domain of the SDoH. If the organization has used another alcohol screening tool, confirm it is connected to the SDoH Alcohol Use and Substance Use domains.

### Option 2: SDoH MyChart Questionnaire (Patient Portal Solution)

The SDoH questionnaire can be completed by the patient in MyChart (patient portal). The SDoH questionnaire can be forwarded to MyChart in bulk or individually.

### Updating SDoH Domains for a Patient

While the SDoH may change over time, it is recommended that HCPs document SDoH data routinely as a patient's needs evolve. Since documenting SDoH is a relatively new concept in the EHR, collecting all SDoH information for a patient may require time. Consider adding training for end users on where and how SDoH data can be documented in the EHR.

Once a patient's SDoH have been documented, the information can be displayed in the Snapshot, Plan of Care, or Storyboard to create awareness about including health equity factors beyond a patient's clinical needs.

For all SDoH domains, a print group can be used to display all SDoH domain data for clinical staff members.

# 04. Identification of Immunization Care Gaps and SDoH Domains

Patients may have immunization care gaps with overlapping gaps in one or more of the SDoH domains. The standard EHR reporting tools can be used to find patients who may be due for an immunization and have concurrent SDoH domain gaps.

Two end user reporting tools are available in Epic for creating a patient list that can be accessed by most end users: Reporting Workbench and SlicerDicer. Instructions for both solutions are included on the following pages; however, because SlicerDicer does not include patient outreach functionality and Reporting Workbench does, the latter may be the optimal solution.

**Adding SDoH domain information to reports**

There are 2 options for adding SDoH information to a report:

### Option 1: Using the SDoH ICD-10 codes

Unique ICD-10 codes are available for documenting SDoH. An HCP can add the ICD-10 SDoH diagnosis code to a patient's chart to document the SDoH domains. Once documented, the ICD-10 code can be leveraged as a filter criterion.

The codes below are examples of ICD-10 codes for SDoH as provided by the CDC[3]:

- Z55 – Problems related to education and literacy
- Z56 – Problems related to employment and unemployment
- Z57 – Occupational exposure to risk factors
- Z58 – Problems related to physical environment
- Z59 – Problems related to housing and economic circumstances
- Z60 – Problems related to social environment
- Z62 – Problems related to upbringing
- Z63 – Other problems related to primary support group, including family circumstances
- Z64 – Problems related to certain psychosocial circumstances
- Z65 – Problems related to other psychosocial circumstances

# 04. Identification of Immunization Care Gaps and SDoH Domains (continued)

To use the SDoH domains as a criterion in the report:

- In Reporting Workbench, **select the Diagnosis by Code criterion** and **enter the desired ICD-10 code(s) from the list on** **page 7**
- In SlicerDicer, **select the Diagnosis criterion, set the mode to ICD-10 CM** and **enter the desired ICD-10 code(s) from the list on** **page 7**

Example scenario using Reporting Workbench: Create a list of patients with an overdue vaccination and transportation-related problems limiting access to healthcare

**NOTE:** The below instructions help health systems create a list of patients with an overdue vaccination and transportation-related problems that limit access to healthcare. It is recommended that the health system repeat the instructions below for each of the Z-codes listed on page 7, and any additional relevant ICD-10 codes, to identify and quantify SDoH areas that warrant further attention and support. It is the responsibility of the health system to identify relevant ICD-10 codes related to SDoH.

1. **Access Reporting Workbench (click the Epic logo > Reports > My Reports).**
2. **Navigate to the Library tab** from the Reports menu.
3. **Enter "generic criteria"** in the search field and **click Search**.
4. **Select the "Find Patients - Generic Criteria Report"** template and **create a New Report**.
5. The Report Settings field will display. **Click the Criteria tab** in the toolbar.
6. **Enter "status" in the search field** (Filter Criteria).
7. **Select the Patient Status criterion** and **set the status to Alive**.
8. **Enter "diagnosis"** in the search field (Filter Criteria).
9. **Select the Diagnosis by Code criterion**.
10. **Enter** and **select the Z59.82 ICD-10 code for Transportation Insecurity**

    **NOTE:** Enter any additional desired ICD-10 Z-code(s) to include multiple social domains.
11. **Enter "immunization" in the search field** (Filter Criteria).

# 04. Identification of Immunization Care Gaps and SDoH Domains (continued)

12. **Select the desired immunization criteria**. If the desired immunization criterion is not available, **click + Add new criterion and select it from the Add Criterion window**. For example, consider the "Imm get dose count given a reference date" criterion and set the details to:
    a. Immunizations: Enter the vaccine mnemonic
    b. Start date: N/A
    c. When received: Ever
    d. Relationship: Less than
    e. Imm get dose count given a reference date: enter the dose count, for example, 1
13. Once all the criteria have been added, **set the Criterion Logic to AND**.
14. In the General tab, **enter the desired report name** (eg, "Transportation insecurity vaccination report") **and a description**.
15. **Select all the desired display columns** (DOB [Date of Birth], patient name, etc) to include in the report.
16. In the Detailed view section, **enter and select the Reporting Workbench Health Maintenance View**.
17. **Click Save and then Run** to create the Patient List. The list will display all patients matching the criteria. **Use the filters to narrow down the Patient List or export to Excel**.

**Important Notes:**

- The "Patients with Immunization Deficiency" report template is a valid alternative to the "Find Patients - Generic Criteria Report" report template. Select the desired immunization series or immunization family
- The "HM: Has Topic" criterion may be considered as an alternative when other criteria are not available. In Step 12 (above), enter the "HM: Has Topic" criterion in place of the "Imm get dose count given a reference date" criterion currently shown in this step and enter and select the desired health maintenance topic
- To add "Health Literacy" as a domain, consider ICD-10 code Z55.6. The patient's primary language may be added by selecting it as a criterion or display column

# 04. Identification of Immunization Care Gaps and SDoH Domains (continued)

Example scenario using SlicerDicer: Create a list of patients with an overdue vaccination and transportation-related problems limiting access to healthcare

**NOTE:** The below instructions help health systems create a list of patients with an overdue vaccination and transportation-related problems that limit access to healthcare. It is recommended that the health system repeat the instructions below for each of the Z-codes on page 7 of this guide, and any additional relevant ICD-10 codes, to identify and quantify SDoH areas that warrant further attention and support. It is the responsibility of the health system to identify relevant ICD-10 codes related to SDoH.

1. **Access SlicerDicer (click the Epic logo > Reports > SlicerDicer)**.
2. **Select the Patients data model**.
3. **Click New** to start a new query.
4. **Select the desired patient base**.
5. In the Search for criteria field, **enter "status"**.
6. **Select the Patient Status criterion and set the status to Alive**.
7. In the Search for criteria field, **enter "age"**.
8. **Select the Age in years criterion** and **set the age range to 50 years and older**.

   **NOTE:** The age parameter may be set based on a health system's preferences.
9. In the Search for criteria field, **enter "diagnosis"**.
10. **Set the mode to ICD-10** and **enter and select the Z59.82 ICD-10 code for Transportation Insecurity**.

    **NOTE:** enter any desired ICD-10 Z-code here for the social domains.
11. In the Search for criteria field, enter **"health maintenance"**.
12. **Select the "Health Maintenance Topic" criterion** and **enter the desired immunization series. Select it from the list. Select the Overdue status from the available options** and **complete all details**.
13. **Confirm the logic** in the Population section in the middle of the screen.
14. In the Visual Options section, **select the last icon on the first row** to view the results. If desired, **right-click the bar with the patient results** and select **Export the Slice to Reporting Workbench** if Reporting Workbench is preferred to manipulate the results.

# 04. Identification of Immunization Care Gaps and SDoH Domains (continued)

15. **Select the General tab and complete all report details**, such as name and description.
16. **Click Run** to execute the report. The list will display all patients matching the criteria.
17. To refine the results of the patient query, **click the Filters tab**. **Select the radio button next to the desired filter criteria** to narrow down the patient list.
18. **Export the data** for further manipulation if desired.

### Option 2: Adding SDoH information as display columns

SDoH information can be added to Reporting Workbench reports to show a patient's risk in each of the documented SDoH domains. Once the display columns have been added to the report, information can be filtered based on the SDoH columns.

Consider the following available columns:

- Alcohol Use – 70764 - Last Alcohol Use Concern Level (SDoH Domain)
- Depression – 70757 - Last Depression Concern Level (SDoH Domain)
- Financial Resource Strain – 70756 - Last Financial Resource Strain Concern Level (SDoH Domain)
- Food Insecurity – 70760 - Last Food Insecurity Concern Level (SDoH Domain)
- Health Literacy – 70781 - Last Health Literacy Concern Level (SDoH Domain)
- Housing Stability – 70762 - Last Housing Stability Concern Level (SDoH Domain)
- Intimate Partner Violence – 70765 - Last Intimate Partner Violence Concern Level (SDoH Domain)
- Physical Activity – 70759 - Last Physical Activity Concern Level (SDoH Domain)
- Postpartum Depression – 70763 - Last Postpartum Depression Concern Level (SDoH Domain)
- Social Connections – 70766 - Last Social Connections Concern Level (SDoH Domain)
- Stress – 70758- Last Stress Concern Level (SDoH Domain)
- Tobacco Use – 70755 -Last Tobacco Use Concern Level (SDoH Domain)
- Transportation Needs – 70761 - Last Transportation Needs Concern Level (SDoH Domain)
- Utilities – 70780 - Last Utilities Concern Level (SDoH Domain)

# 05. Setting Up Patient Outreach

Once a patient list is created, identified patients can be reached through Reporting Workbench's patient outreach functionality using their preferred communication method. The patient's preferred communication method is typically documented within the Patient Profile section of the demographic profile and will determine how a patient receives any outbound communication from their health system. There are 4 communication options available:

- Mail
- Phone
- MyChart (Epic's patient portal solution)
- Do Not Contact

Patients who are marked as "Do Not Contact" are excluded from any automated patient outreach activity.

Reporting Workbench and/or SlicerDicer can be used to identify patients with vaccine care gaps. Both are generally available to end users. Use the steps detailed in Section 4 of this guide to identify patients with an immunization care gap and one or more SDoH domain gaps.

**Instructions for Setting Up Patient Outreach**

Once patients have been selected in the previous step, **click the Communication button** in the menu to set up the outreach. Setting up patient outreach involves **2 steps**:

1. Add the patient education content to the EHR, and
2. Leverage the uploaded content for all outreach methodologies.

### Step 1: Integrate the recommended patient education content in the EHR by creating a new letter template

1. **Click the Epic logo > Tools > SmartTool Editors > Letter Template**.
2. **Browse the available catalog** to find a suitable template. There may be many letter templates that are appropriate to personalize for the outreach.
3. **Complete the settings** for the letter template:
   a. Set the Restrictions to "MR Letter Template" and "MR Letter Encounter".
   b. **Enter a unique name** that follows the health system's naming conventions.
   c. Complete the letter template. Navigate to the patient education content to integrate the template into the EHR. Sample content can be found here. **Add the content** and **save the record**.

Alternatively, SmartText can be used to create patient education content:

1. **Open the SmartTool Editor** and **select the SmartPhrase option** (**click the Epic logo** in the top left and select MySmartPhrases or use the search feature).
2. **Create a new SmartPhrase** with a unique name according to the organization's naming convention, for example, "SDoHVaccineInfo".
3. **Select the General button** and **input the desired information**.
4. **Click Accept** to save your changes.
5. **Click Close** to exit the SmartPhrase activity.

## Step 2: Set up the outreach methods

### Setting up the Phone Tab

1. **Click the Phone tab**.
2. **Set the desired InBasket recipient**—for example, a care manager assigned to the campaign.
3. **Set the priority as desired**.
4. **Set the Routing Action to "Initiate Calls"** and the **Reason for Call to "Missing Vaccines"**.
5. **Create an outreach message** as desired. A suggested script is provided below:

"Hello, this is [Name] calling from [Health System Name].

We're reaching out because your health is important to us, and we want to make sure you're protected against vaccine-preventable diseases like shingles, RSV, flu, and COVID-19.

Getting vaccinated is one of the safest ways for you to protect your health. Vaccines help prevent getting and spreading vaccine-preventable diseases that could result in poor health.

We're here to provide you with the support you need, including scheduling, answering questions, or assisting with transportation needs. For additional information, call us at [Phone Number]."

**Note:** The health system may have various phone outreach options, ranging from an Interactive Voice Response (IVR) system to manually reaching out to patients. Please contact your EHR team for additional support if needed.

## Setting up the Mail tab

1. **Click** the Mail tab.
2. **Enter a reason for the letter**—for example, "Missing Vaccines".
3. **Use the Template search field** to find the optimal template. Consider using terms, such as "SDoHVaccineInfo". **Click on the desired template**.
4. **Review the template** to ensure all information displays as desired. **Select the radio button next to Show Template** to display the templated letter or **select the radio button next to Show Preview For** to display the customized letter for the selected patient.

A sample message is provided below:

SUBJECT: Stay Up to Date With Vaccines

Dear [Patient Name],

At [Health System Name], we know how important it is to stay protected—especially when circumstances make it hard to prioritize your health.

Getting vaccinated is one of the safest ways for you to protect your health. Vaccines help prevent getting and spreading vaccine-preventable diseases that could result in poor health, such as RSV, shingles, flu, and COVID-19.

We're here to provide you with the support you need, including scheduling, answering questions, or assisting with transportation needs.

Call us today at [Phone Number] to schedule your vaccine appointment.

Thank you!

## Setting up the MyChart tab

1. **Click** the MyChart tab.
2. **Enter a subject line**—for example, "Missing Vaccines".
3. **Set the Reply options**—for example, "Allow reply directly to me".
4. Use the Template search field to find the optimal template. Consider using terms, such as "SDoHVaccineInfo". Click on the desired template. (This is the template or SmartText that was set up in Step 1).

A sample message is provided below:

SUBJECT: Stay Up to Date With Vaccines

Dear [Patient Name],

At [Health System Name], we know how important it is to stay protected—especially when circumstances make it hard to prioritize your health.

Getting vaccinated is one of the safest ways for you to protect your health. Vaccines help prevent getting and spreading vaccine-preventable diseases that could result in poor health, such as RSV, shingles, flu, and COVID-19.

We're here to provide you with the support you need, including scheduling, answering questions, or assisting with transportation needs.

Call us today at [Phone Number] to schedule your vaccine appointment.

Thank you!

**Note:** Any outreach can be tracked in Reporting Workbench or at the patient level under the Patient Outreach History section.

# 06. Community Resources to Cover SDoH Care Gaps

The Community Resources directory includes all services and products that are available for any of the SDoH domains. The directory includes both national and local service providers. Depending on the SDoH domain, for example, for the Transportation SDoH domain, a partnership with local ride-service providers can be created to serve the needs of patients with transportation needs to and from care facilities.

Some SDoH domains may have nationwide service providers. This list can be enriched with local providers not included in the standard-released Community Resources directory. The directory can be searched by domain and location. Favorite service providers can be marked if desired. A geocoding service is available to match a service provider to a patient's home address, which may be helpful for some SDoH domains.

# 07. Disclaimers

- The customer (ie, physician, medical group, IDN) shall be solely responsible for the implementation, testing, and monitoring of the instructions to ensure proper orientation in each customer's EHR system
- Capabilities, functionality, and setup (customization) for each individual EHR system vary. GSK shall not be responsible for revising the implementation instructions it provides to any customer if the customer modifies or changes its software or the configuration of its EHR system, after such time as the implementation instructions have been initially provided by GSK
- While GSK tests its implementation instructions on multiple EHR systems, the instructions are not guaranteed to work for all available EHR systems and GSK shall have no liability thereto
- While EHRs may assist providers in identifying appropriate patients for consideration of assessment, treatment, and referral, the decision and action should ultimately be decided by a provider in consultation with the patient, after a review of the patient's records to determine eligibility, and GSK shall have no liability thereto
- The instructions have not been designed to and are not tools or solutions for meeting Advancing Care Information and/or any other quality/accreditation requirement
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# **08.** Notes

**References: 1.** Vogelsang EM, Polonijo AN. Social determinants of shingles vaccination in the United States. *J Gerontol*. 2022;77(2):407-412. Accessed September 19, 2025. https://academic.oup.com/psychsocgerontology/article/77/2/407/6259336?login=false **2.** Crowe S, Kimiecik C, Adeoye-Olatune OA, et al. Social determinants of health-based strategies to address vaccination disparities through a university-public health partnership. *J Clin Transl Sci*. 2024;8(1):e66. Accessed September 19, 2025. https://pmc.ncbi.nlm.nih.gov/articles/PMC11058580/. **3.** ICD-10-CM TABULAR LIST of DISEASES and INJURIES. Centers for Disease Control and Prevention. 2022. Accessed December 5, 2025. https://ftp.cdc.gov/pub/health_statistics/nchs/publications/ICD10CM/2022/icd10cmtabular-2022-April-1.pdf


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