Electronic Health Record (EHR) Instructions
for the Oracle Health EHR System

Social Determinants of Health (SDoH) Guide

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01. Background and Limitations

This SDoH Guide was created specifically to leverage Oracle Health's SDoH functionality to help health systems achieve improved immunization rates for appropriate patients treated by doctors using the Oracle Health 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 Oracle Health'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 Oracle Health 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 most recent Oracle Health code set. Some configurations to the EHR system may be required by a clinical analyst.

02. SDoH Overview

Leveraging Oracle Health 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]

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

- Personal Characteristics
- Family & Home
- Money & Resources
- Social & Emotional Health

03. SDoH Documentation

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

Option 1: SDoH PRAPARE PowerForm for HCPs

PowerForms are commonly used to document vital signs, histories, lab results, and other clinical variables. In the Ad Hoc forms menu, the SDoH PowerForm 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 the patient's chart and can be displayed in Oracle Health for other HCPs to view.

Documenting the SDoH domains can be done by using the Oracle Health-released PRAPARE PowerForm. As a best practice, review current documentation practices for SDoH data and confirm alignment with the established SDoH domains.

03. SDoH Documentation (continued)

Option 2: SDoH Patient Portal Questionnaire

The SDoH questionnaire can be completed by the patient in the patient portal. The SDoH questionnaire can be forwarded to the patient portal 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 Flowsheet to create awareness about including health equity factors beyond a patient's clinical needs.

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.

Dynamic Worklist is an end user reporting solution available in Oracle Health to create a patient list and can be accessed by most end users.

Adding SDoH domain information to reports

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 a block of ICD-10 category 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 a Dynamic Worklist report, **select the Conditions criterion** and **select the desired condition(s) from the list on** **page 7**

Example scenario: 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.

Dynamic Worklist, a reporting tool generally available to end users, offers functionality to identify patients.

1. **Select Dynamic Worklist** from the menu. The Dynamic Worklist wizard will display.
2. **Select Create Worklist** from the List Actions drop-down menu.
3. The Create New Worklist wizard contains 3 tabs: Worklist Type, Criteria, and Summary.
    a. In the Worklist Type Tab:
        i. **Enter the desired report name** in the Name Your Worklist field, e.g., "Immunization and SDoH Campaign".
        ii. **Select the radio button for Group/Provider or Location as desired**. The Group/Provider and Location are based on the organizational structure.
        iii. **Complete the Group's/Provider's Relationship Type or the Location's Facility, Building, and Unit. Select all facilities from the health system**.
        iv. For the Relationship Type, **select all roles**.
        v. **Click Next**.

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

b. In the Criteria Tab:

- **i.** **Click** the Age criterion and **enter the desired patient age**.
- **ii.** **Click** the Health Maintenance criterion and **enter and select the desired immunization series**.
- **iii.** **Click** the Conditions criterion and **select the condition for Transportation Insecurity**.
- **iv.** **Click Next**.

c. In the Summary Tab:

- **i.** **Review the selected criteria** and **click Finish** to run the Patient List.
- **ii.** The column will display all the patient information, which can be filtered if desired.
- **iii.** **Enter the count of patients** in the worksheet.
- **iv.** **Click the List Actions drop-down menu** and then **click Export** to export the list of patients to Excel.

05. Setting Up Patient Outreach

Once a patient list is created, identified patients can be reached through the Dynamic Worklist 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
- Patient Portal
- Do Not Contact

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

Dynamic Worklist 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 Generate Communication button** in the menu to set up the outreach.

The instructions to set up the communication method and a sample message for each method are provided below:

1. **Click the Generate Communication button**. The Generate Communication template will display.
2. In the Subject field, **select a title from the list**. To create a custom Subject, **click Other** and **enter a free-text subject line**.
3. In the Note Type, **select a type** from the list (to save the outreach to the patient chart). **Check the radio button next to Save to Chart**.
4. In the Sent on Behalf of field, **select the name of the provider**.
5. On the right-hand side of the window, **enter the text in the text editor**. **Complete the outreach template**. Tokens can be used to personalize the message.
6. **Click Generate** to forward the message. The patient's preferred communication will be respected.

Setting up the Phone Message

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 Message

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 patient portal message

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!

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 March 2, 2026. 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 March 2, 2026. https://pmc.ncbi.nlm.nih.gov/articles/PMC11058580/ **3.** ICD-10-CM Tabular List of Diseases and Injuries. Centers for Disease Control and Prevention. 2025. Accessed March 2, 2026. https://www.cms.gov/medicare/coding-billing/icd-10-codes

NPUS-GVULBND260010 February 2026
Produced in USA.