Social Determinants of Health: A New Model to Improve Health at an FQHC

LOMA LINDA UNIVERSITY HEALTH

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SAC HEALTH SYSTEM

Background

- Social Determinants of Health (SDOH) are risks based on where people are born, live, learn, work, play, worship, & age. Studies suggest SDOH risks influence 40-55% of health outcomes.[1] Patients at highest risk of from SDOH if they have a complex health history requiring multiple providers and specialists.
- The patient population in this 3 cycle Plan-Do-Study-Act (PDSA) QI project at LLUH Family Medicine Residency clinic in a Federally Qualified Health Center (FQHC) often have multiple co-morbidities & complex psychosocial risks. The patients' highest SDOH risks include mental-behavioral health, poverty, lack of physical activity, food & housing insecurity (see Table 1). Family Physicians play a crucial role in screening & addressing SDOH to adjust treatment & avoid poor health outcomes.[2] A team-based approach may be necessary to achieve this goal.3
- A lack of physician/staff education are barriers to identify, document, and refer for SDOH risks. LLUH FQHC Family Medicine Residency continuity clinic used multidisciplinary team-based QI to improve identification, diagnosis, and referral for SDOH with Epic Best Practice Advisories (BPA) & Smart Sets for community referrals. An IBH intervention for patients with uncontrolled diabetes was piloted in the final PDSA cycle this year.

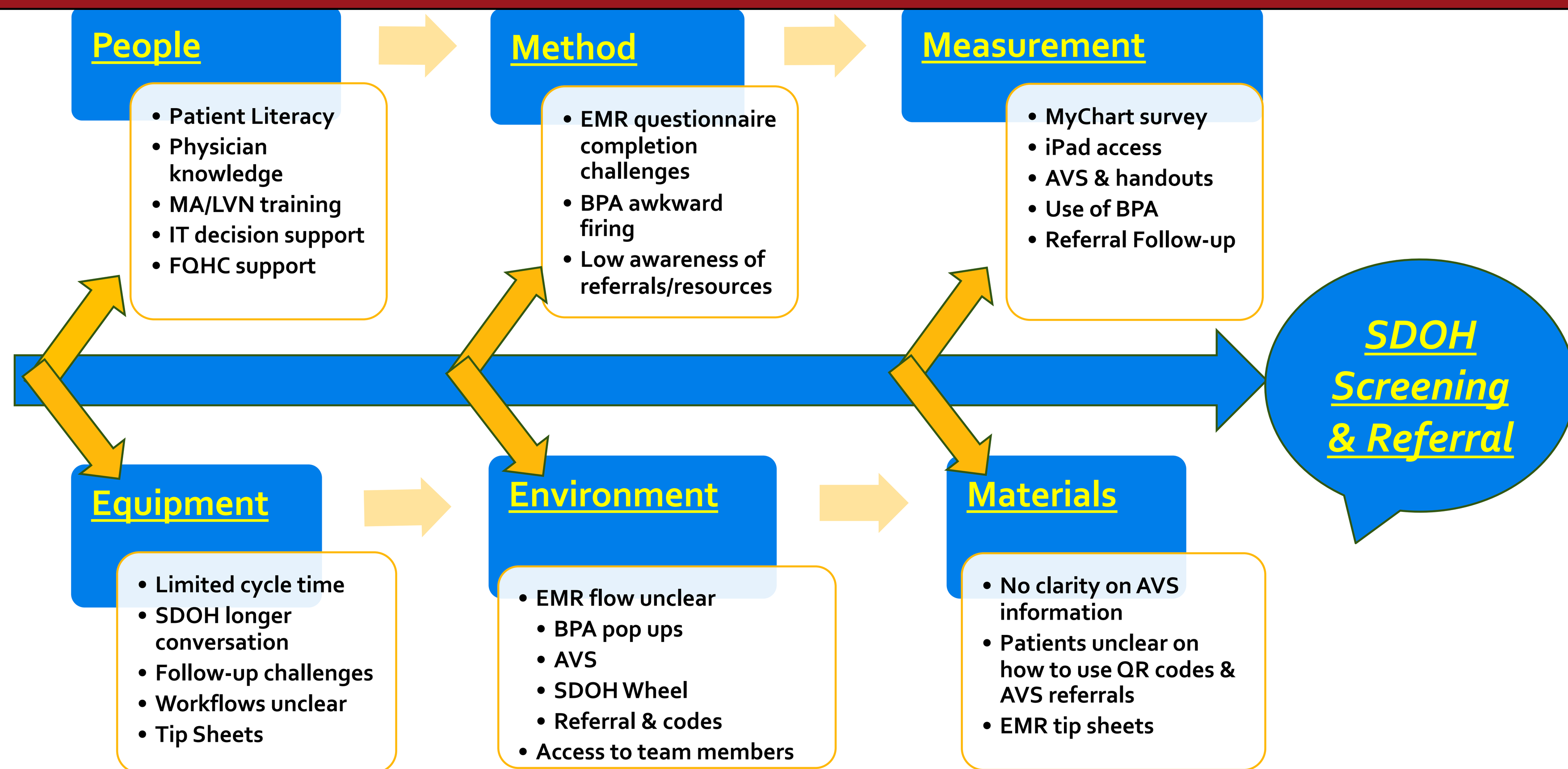
Aim

By June 2023, 3 PDSA cycles will educate physicians & staff about SDOH and new workflows to efficiently identify & diagnose SDOH risks to systematically address & refer for SDOH risks within clinic visits: (1) Expand AVS information; (2) clarify workflows for all team members; (3) pilot a diabetes care path with IBH students.

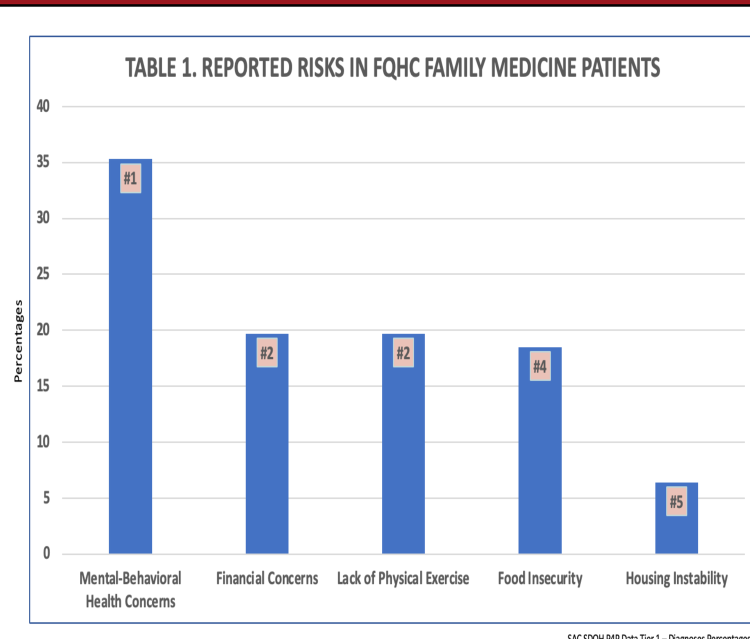
Key Stakeholders

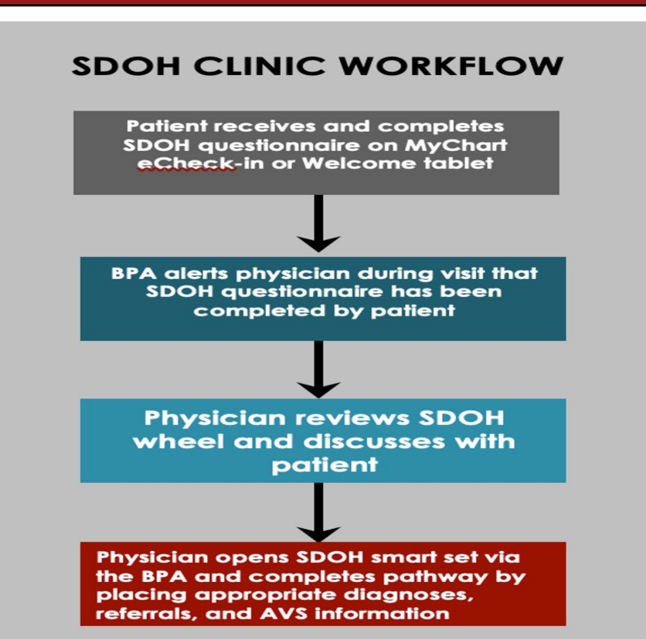
- Patients
- FQHC Staff for Referrals, Scheduling, MAs, LVNs, IBH students & IT support
- Faculty, Attending Physicians, 10 resident QI team members

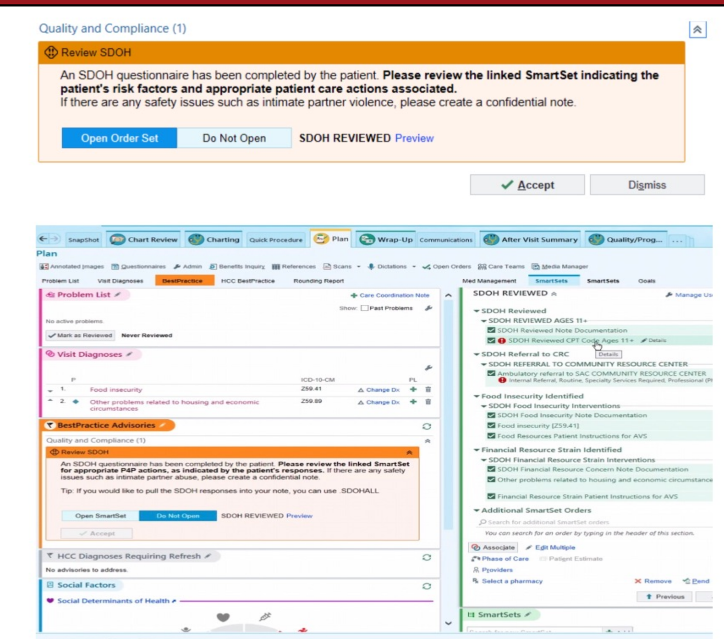
Root Cause Analysis: Fishbone Diagram



SDOH Clinic Workflow







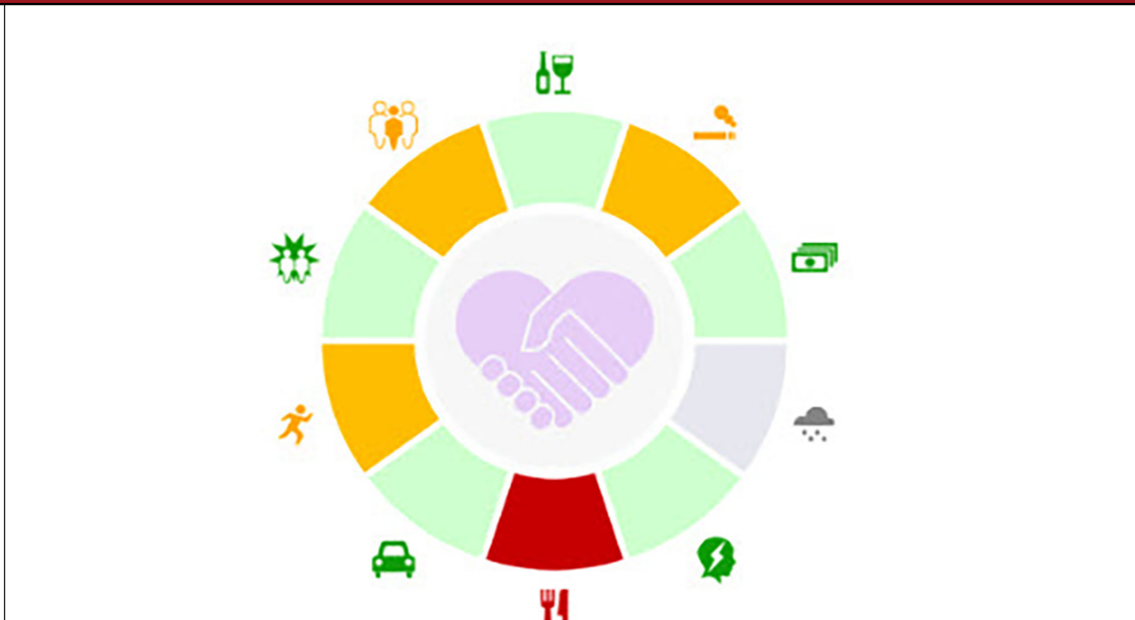
Interventions Across 3 PDSA Cycles

WHAT TO SAY?

"It looks like you might be having some challenges in your life right now and we want to get you connected with things that can help you. Your doctor put some suggestions in this handout that you can do right now."

"In addition, there are also links to resources in your community that can help you." For example,

- Food banks in your zip code
- Housing options to explore in our CRC located to the left of the lobby.
- Having a consult with our Health & Wellness Consultants on our team today to address feeling down and lonely.

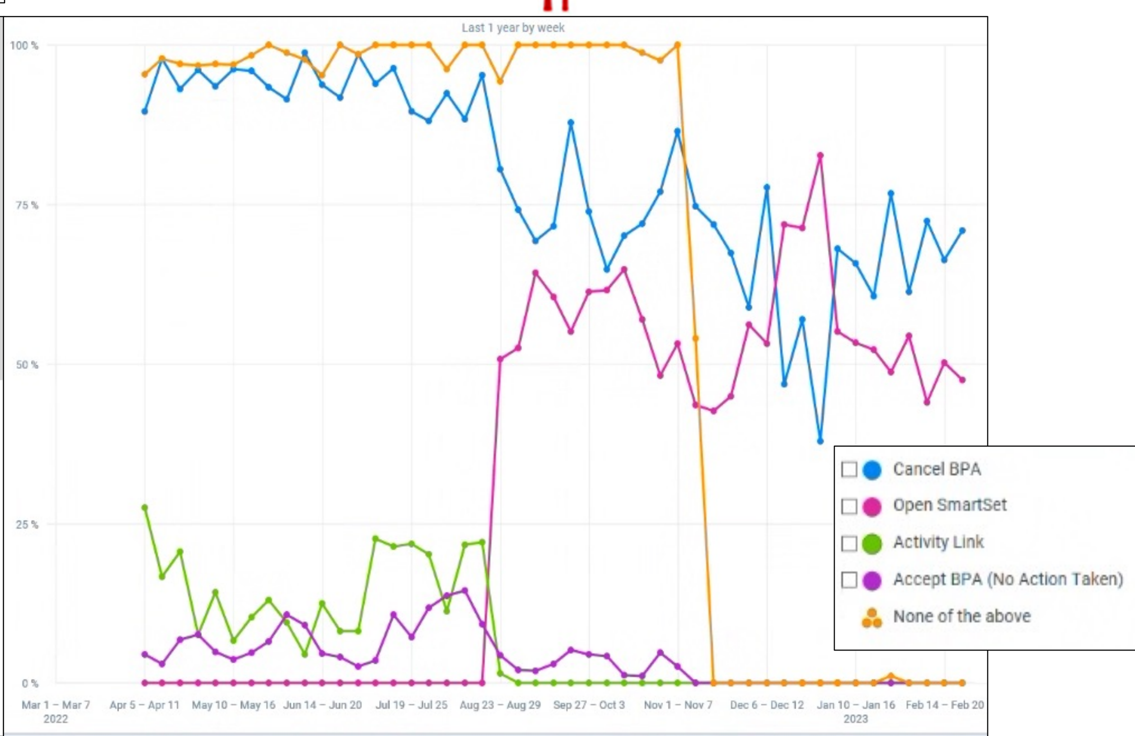


After Visit Summary Inserts automatically drop in with each SDOH Diagnosis to provide tips & Community Referrals

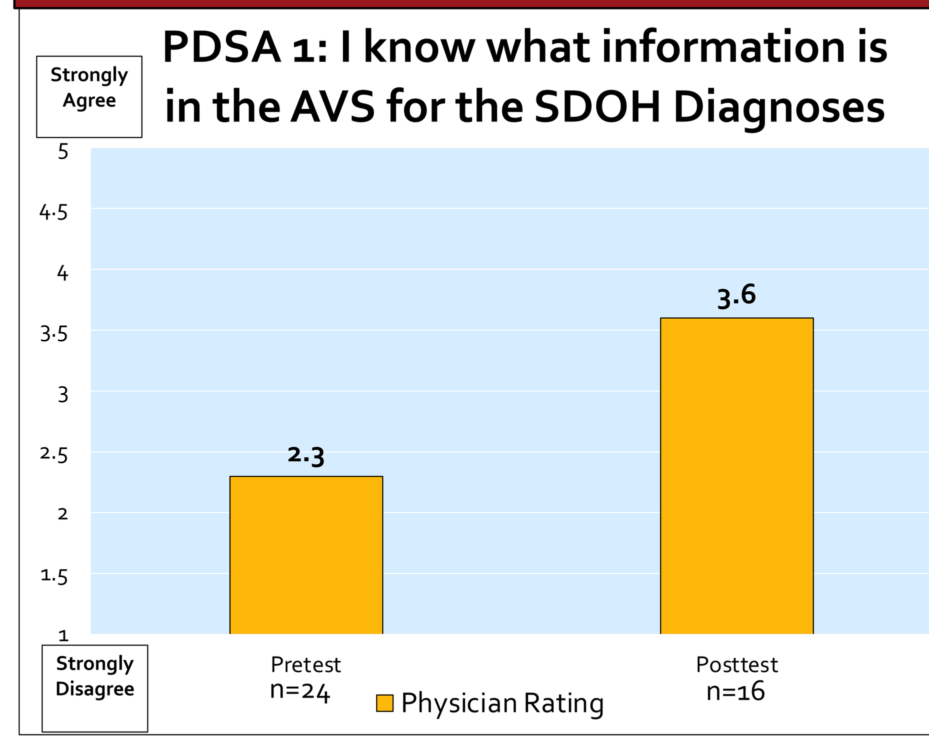
Additional Resources

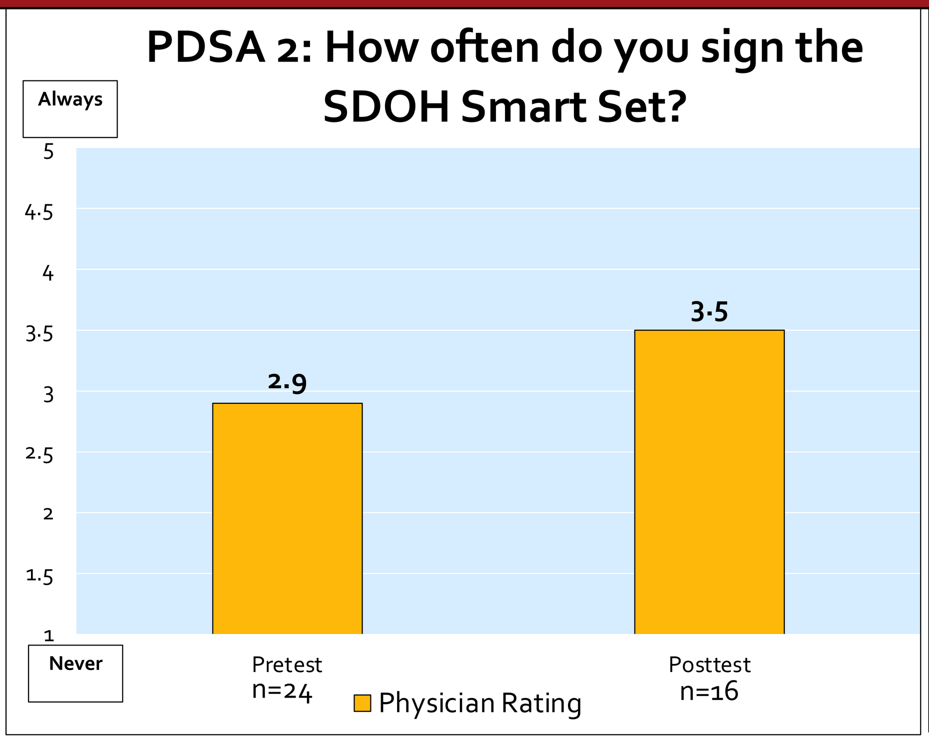
Physical Activity Guideline for Americans 2nd Edition: https://health.gov/sites/default/files/2019-09/Physical_Activity_Guidelines_2nd_edition.pdf

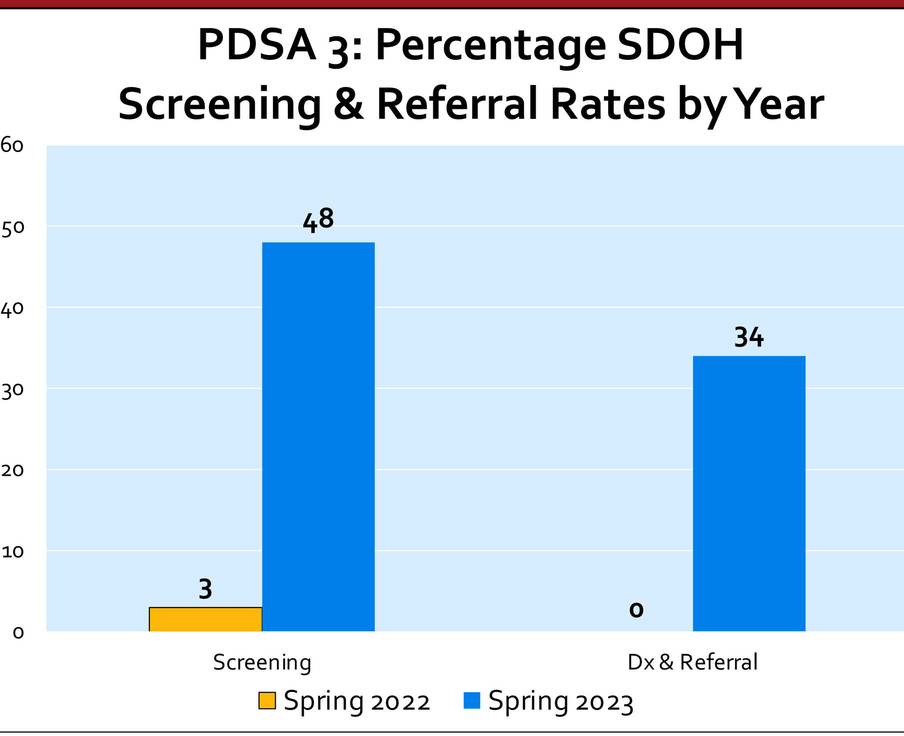
Impact of Physical Activity on Health: https://www.who.int/news-room/fact-sheets/detail/physical-activity



PDSA Cycle Outcomes







Conclusions & Future Directions

- SDOH risks influence health & our PDSA cycles improved awareness and workflows to address risks and refer patients appropriately.
- EMR tools such as the BPA & Smart Set, as well as involving interdisciplinary team members improved SDOH screening & diagnosis with referrals during clinic visits.
- Easier to address SDOH if the risk is related to the reason for visit; else, time constraints restrict addressing this new Medicaid managed care quality metric.
- Patients can be grateful or may feel unfairly labeled (housing challenges vs. homeless).
- A team-based approach can help patients navigate referrals to address these risks.
- **Future Directions**: Assess SDOH in hospital service with IBH team. Enhance team-based engagement with motivational interviewing to help patients move forward for their health journey as we did for patients with uncontrolled DM in PDSA cycle 3 (most often wanted to work on stress management vs. diet/exercise.

References

1. *The Social Determinants of Health* (01/25/203). Center on Integrated Health Care and Self-Directed Recovery. https://www.center4healthandsdc.org/the-social-determinants-of-health.html (Accessed: January 26, 2023).
2. Taylor LA, Tan AX, Coyle CE, et al. Leveraging the Social Determinants of Health: What Works?. *PLoS One.* 2016;11(8):e0160217. Published 2016 Aug 17. doi:10.1371/journal.pone.0160217
3. Gard, L. A., Cooper, A. J., Youmans, Q., Didwania, A., Persell, S. D., Jean-Jacques, M., Ravenna, P., Goel, M. S., & O'Brien, M. J. (2020, January 16).