

## 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.<sup>1</sup> 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.<sup>2</sup> A team-based approach may be necessary to achieve this goal.<sup>3</sup>
- 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

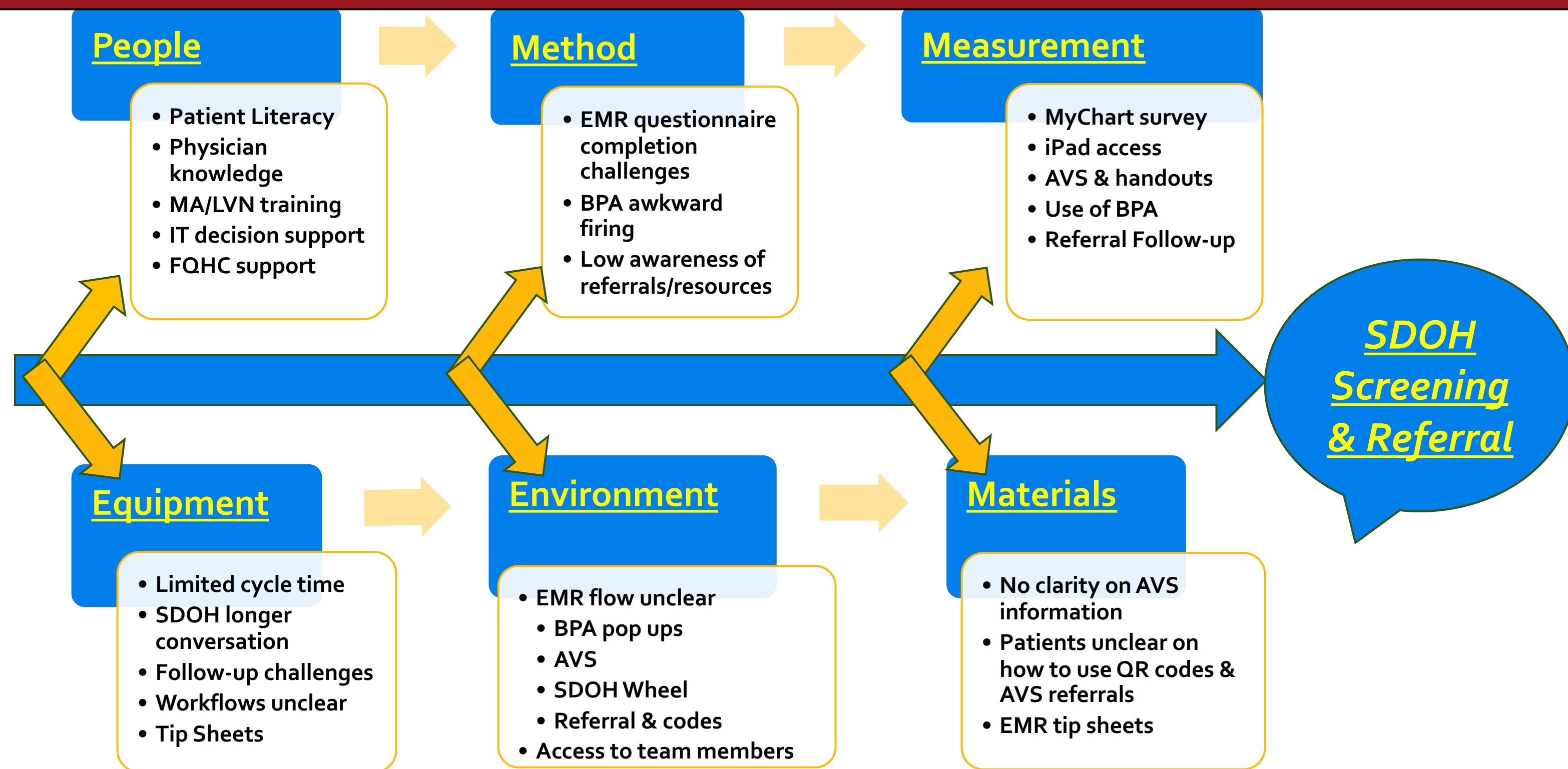
By June 2023, 3 PDSA cycles will educate physicians & staff about SDOH and new workflows to efficiently identify & diagnose SDOH risks to systematically address & refer for SDOH risks within clinic visits: (1) Expand AVS information; (2) clarify workflows for all team members; (3) pilot a diabetes care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



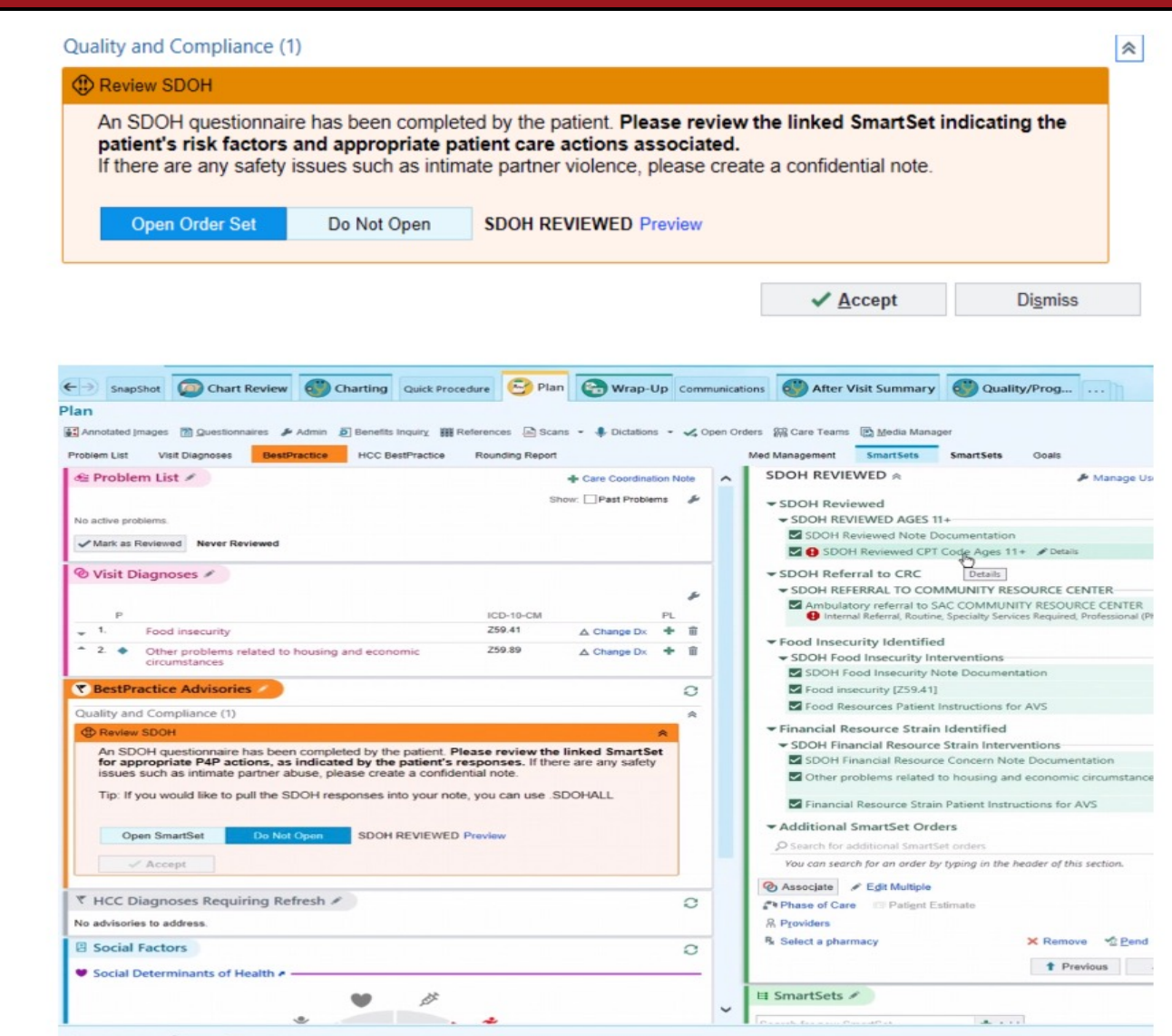
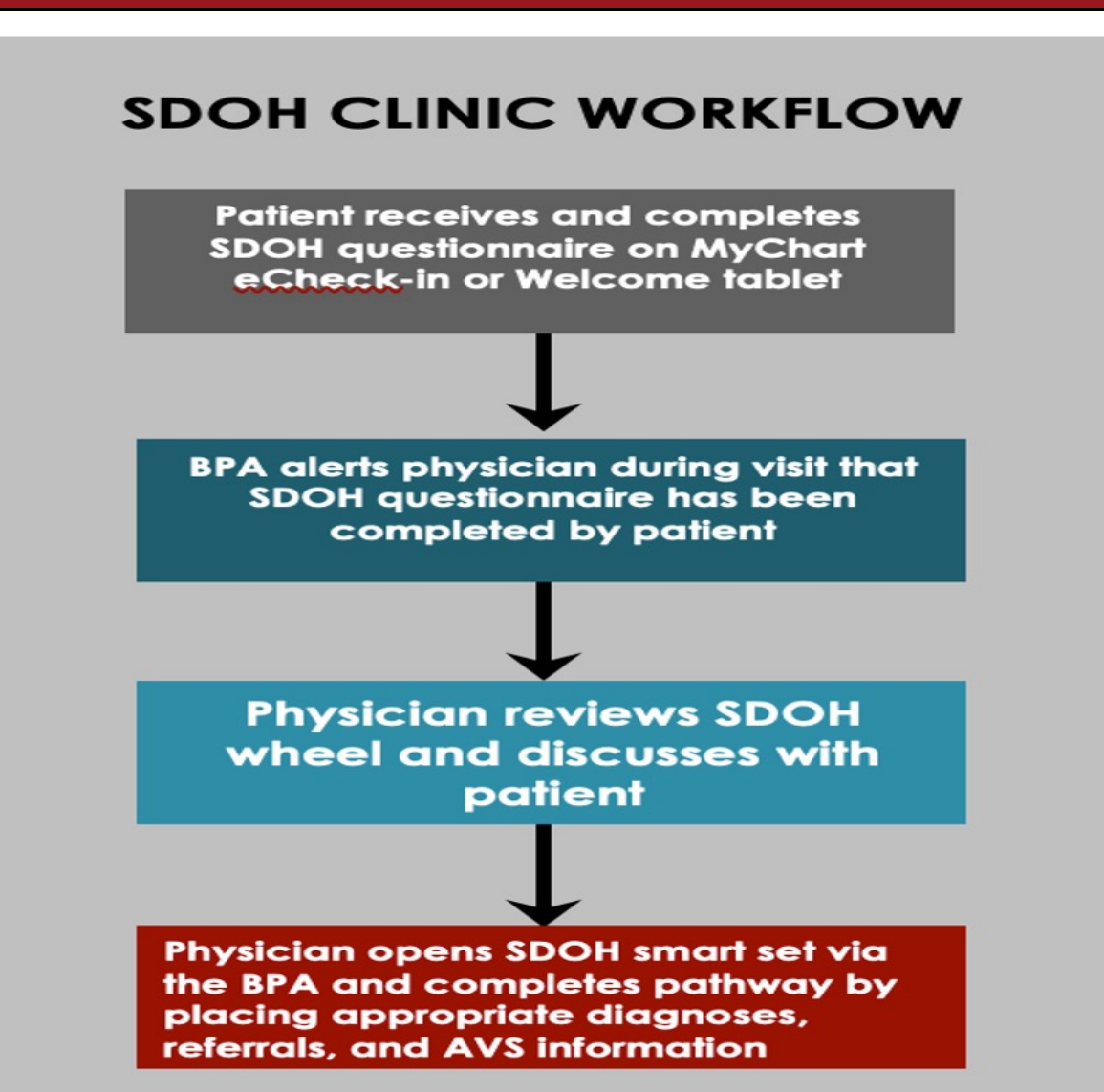
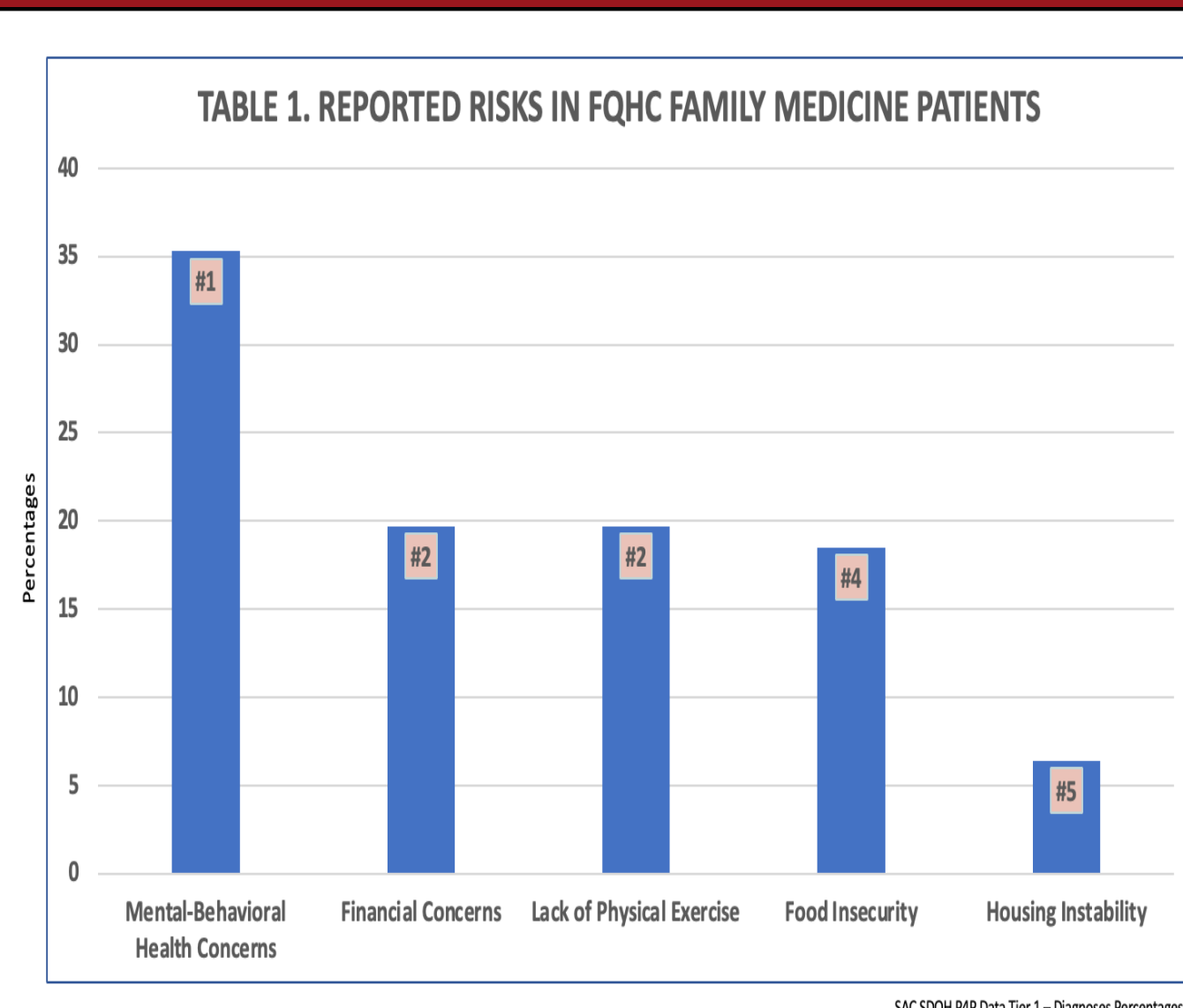
## Key Stakeholders

- 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



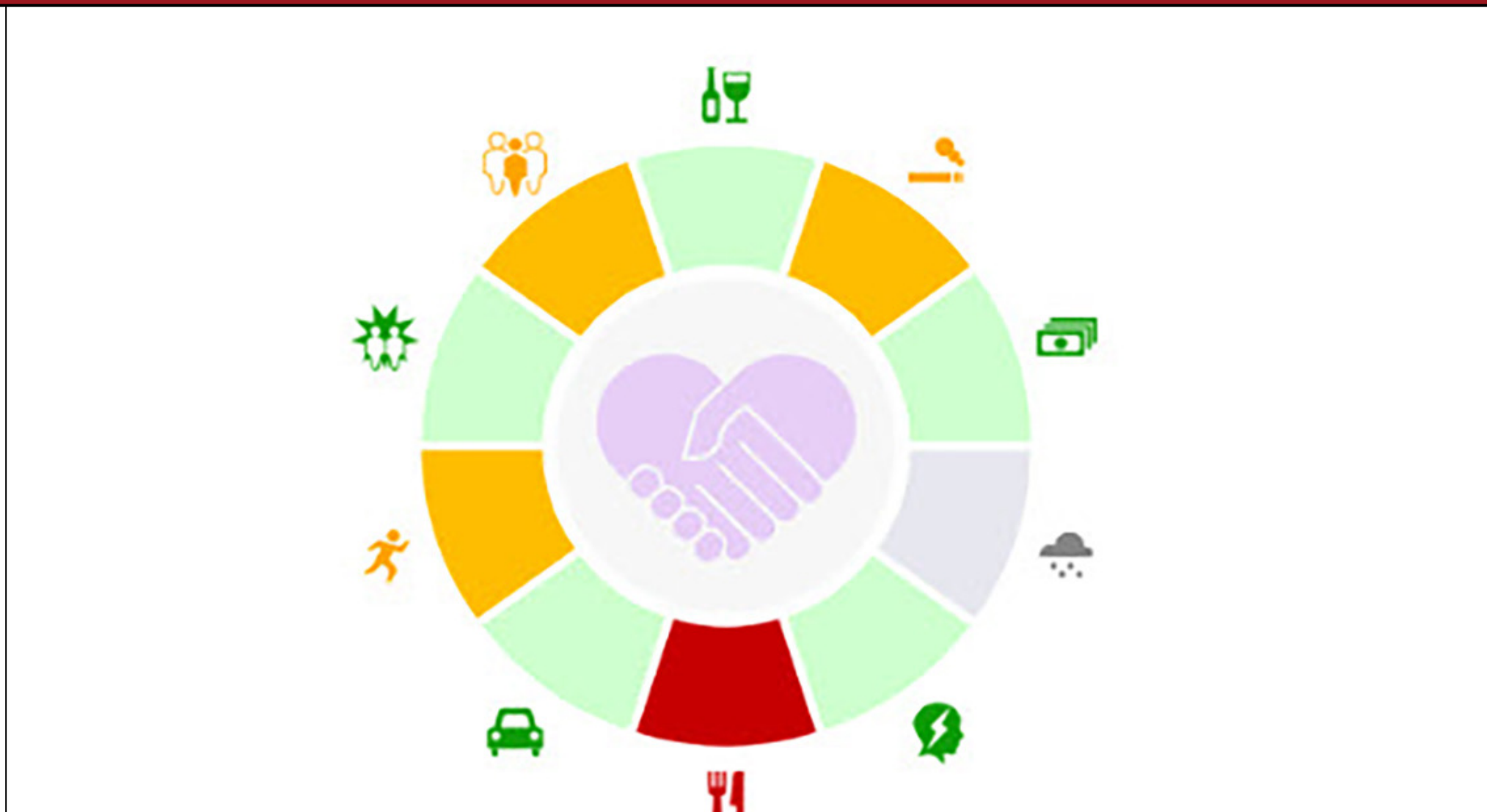
## Interventions Across 3 PDSA Cycles

**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.



Thank you for filling out the Social Determinants of Health questionnaire. We want you to know that we value and appreciate your honesty as it helps us provide better care and resources to you and your family. Based on the answers you provided, we have prepared some reading material and links to resources you might find helpful. If you have any extra concerns or are in need of additional services, please feel free to reach out to your provider.

Regular physical activity is an effective way to improve health conditions regardless of age, sex, ethnicity/race, and current fitness level. Incorporating even small amounts of aerobic and muscle strengthening activity in your day can help significantly reduce the risk of chronic diseases. Other factors that influence risk to chronic illness include sleep quality and quality of life. Your healthcare system encourages you to adopt a more physically active lifestyle to improve your overall health and well-being.

**Key Guidelines for Adults**

- At least 150 minutes (2 hours and 30 minutes) to 300 minutes (5 hours) a week of moderate-intensity or 75 minutes (1 hour and 15 minutes) to 150 minutes (2 hours and 30 minutes) a week of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate- and vigorous-intensity activities. Preferably, aerobic activity should be spread throughout the week.
- Muscle-strengthening activities of moderate or greater intensity that involve all major muscle groups on 2 or more days a week, or these activities provide additional health benefits.

**How Can I Incorporate Physical Activity into my Day?**

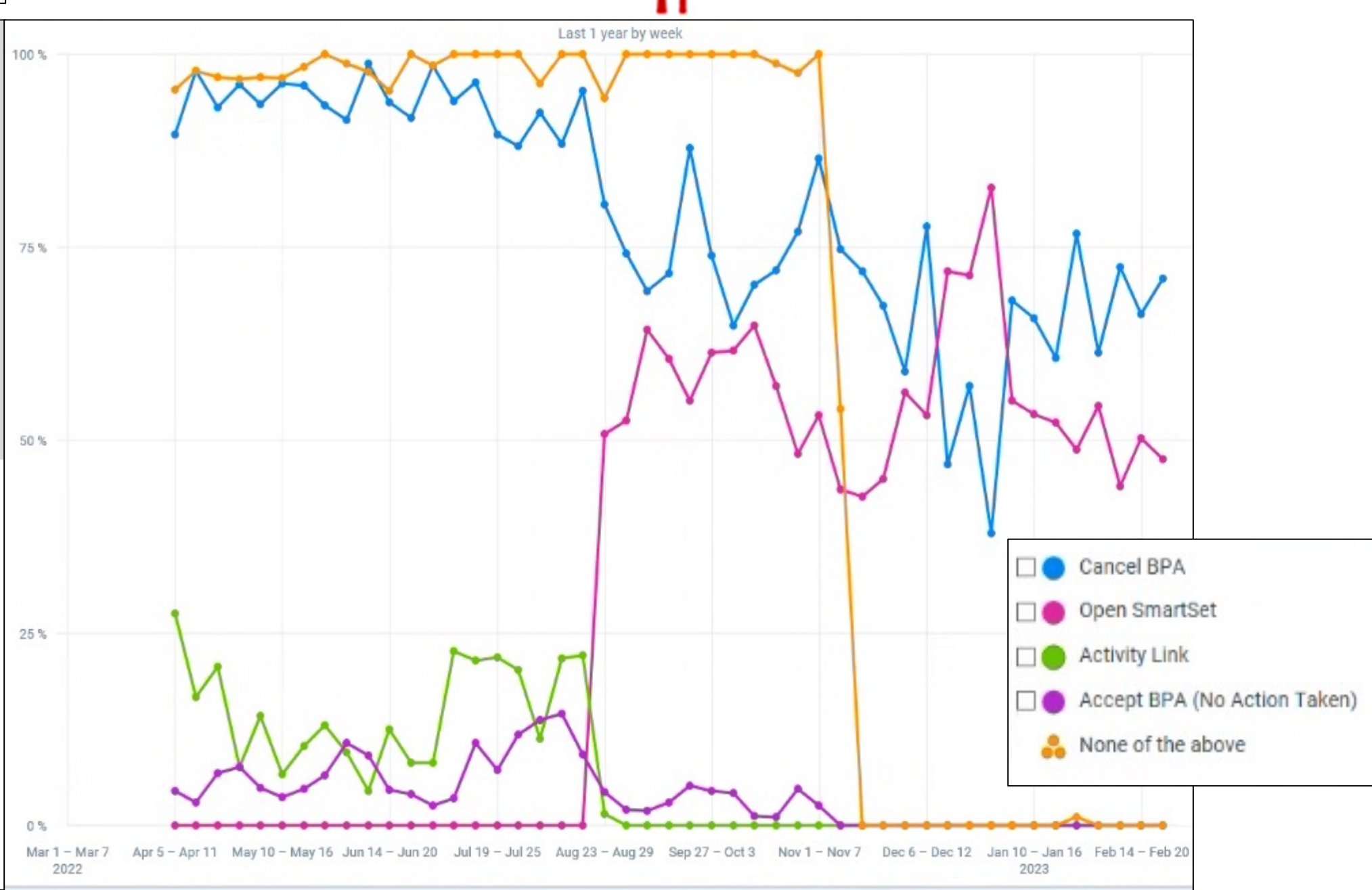
- Personalize the Benefits of Physical Activity. What are some benefits of physical activity that are of value to you? This can be for health benefits, to enjoy more social and recreational sporting activities, or for personal improvement in energy and well-being. Choose an activity that you enjoy.
- Set Specific Goals. This can be unique, personal fitness goals such as running a marathon, distance swimming, or creating a number of dance routines. Specify the amount of time you will dedicate to achieving these goals.
- Find an accountability partner. This is someone that will do these physical activities with you or someone that makes sure you complete the activities you set out to do.
- Walk. Walk whenever possible. Walk instead of driving or park your car further away from your destination. Take a 15 minute walk after a meal. Take the stairs instead of elevators or escalators. Get off the bus a stop early, and walk.
- Move More at Home and Limit Screen Time. Move more and sit less. Instead of watching TV, start a gardening project or yard project. Rake leaves and push lawn mowers. Move in a way that excites you. Here are some suggestions for fun ways to be more active: <https://health.com/move-more>

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

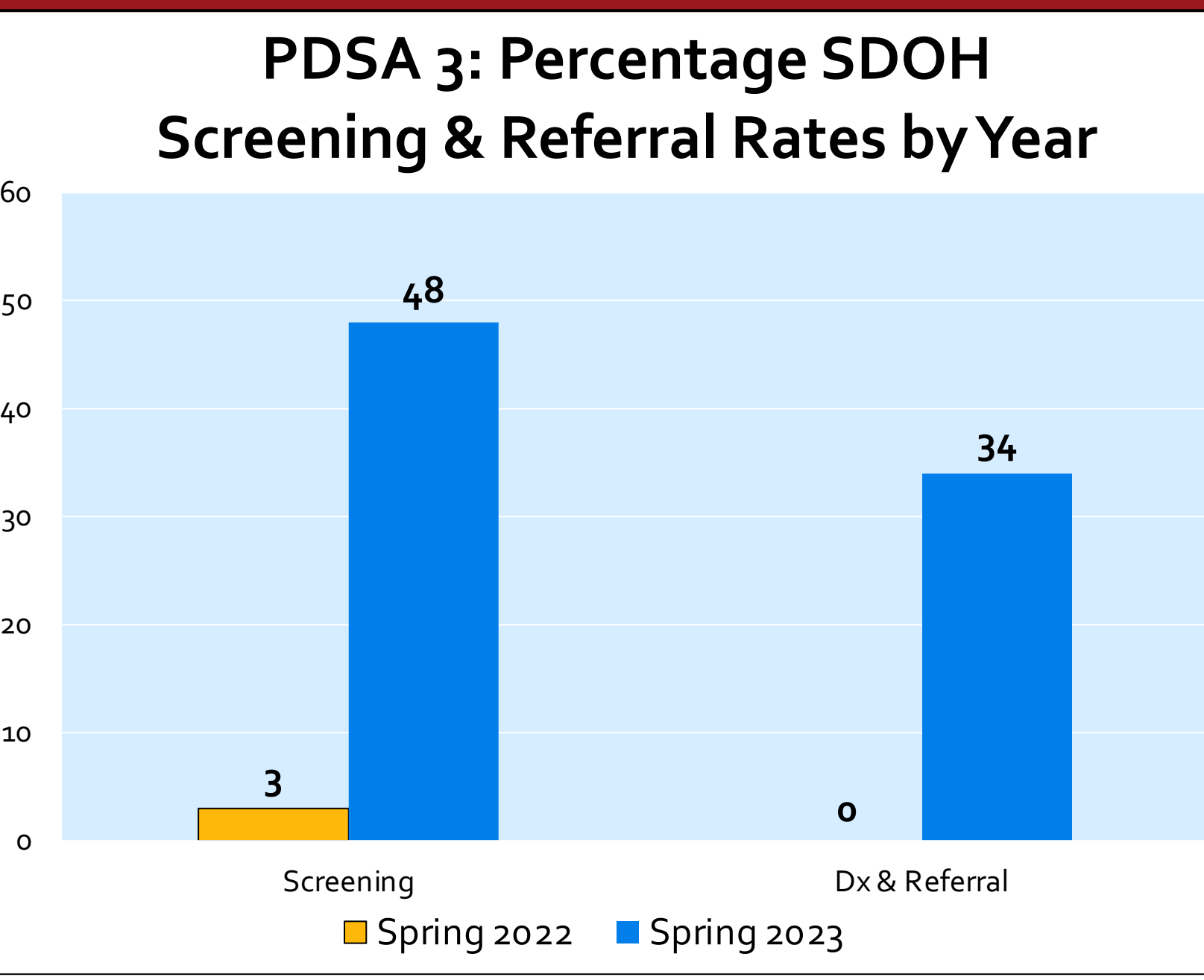
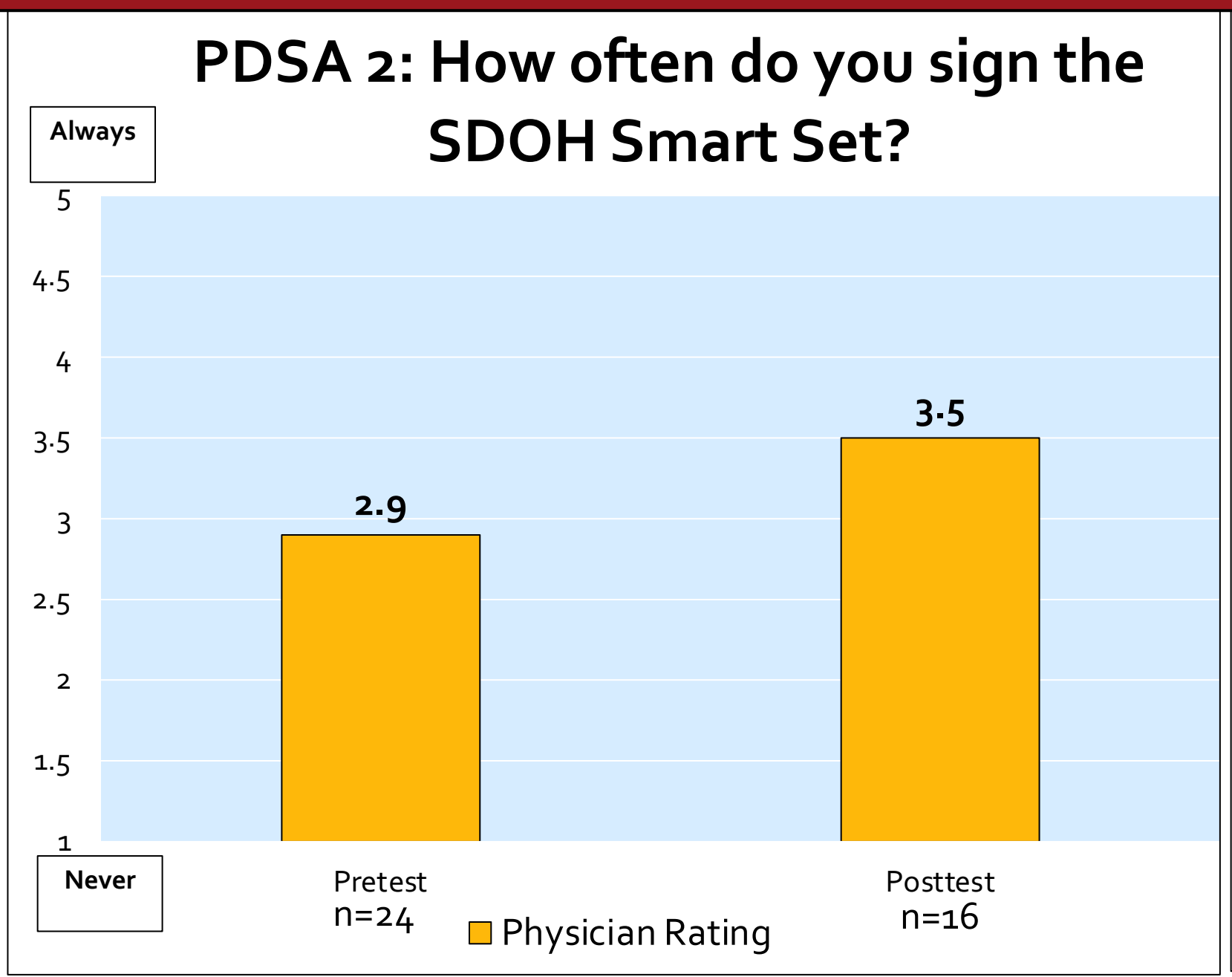
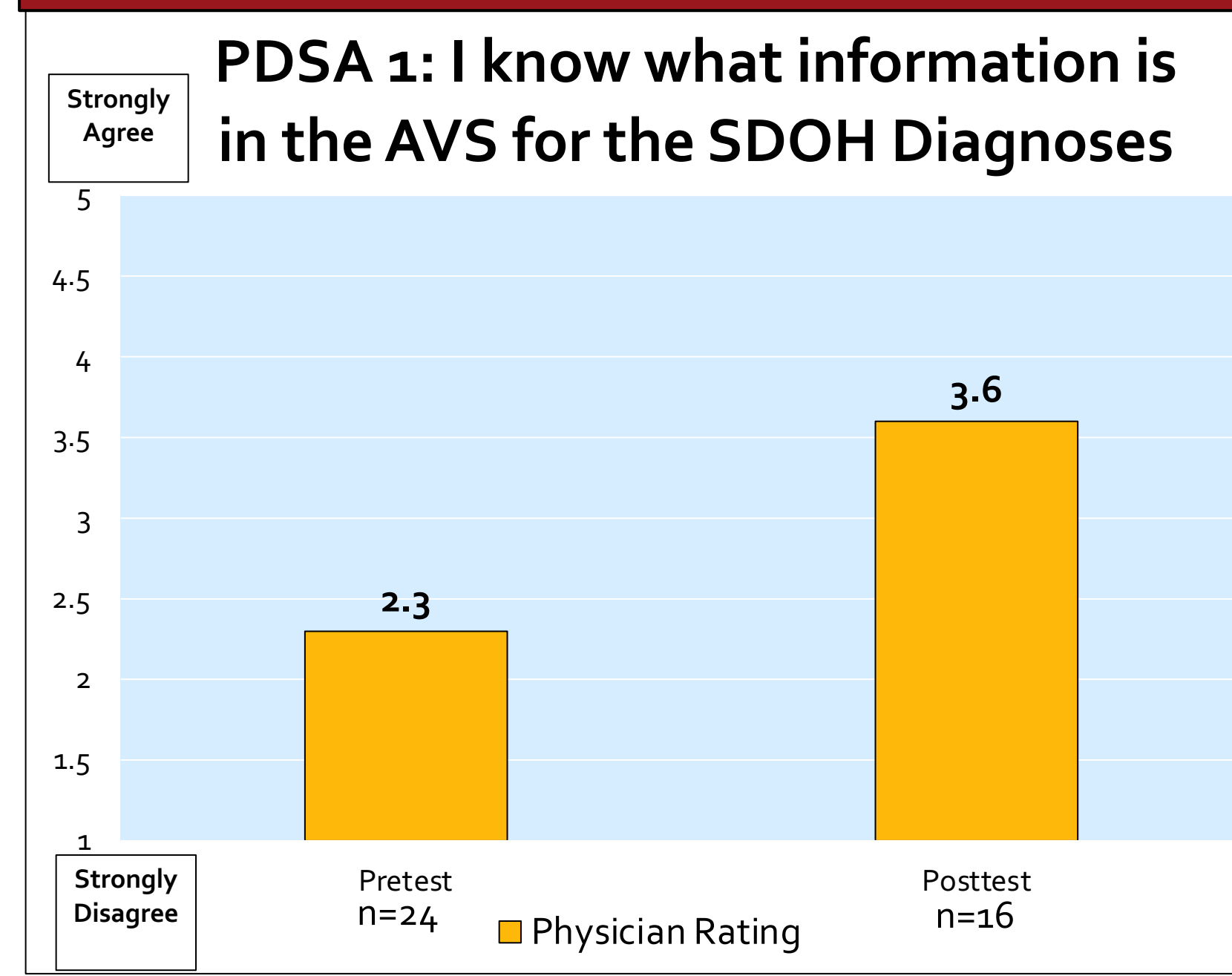
**Additional Resources**

Physical Activity Guideline for Americans 2nd Edition:  
[https://health.gov/sites/default/files/2019-09/Physical\\_Activity\\_Guidelines\\_2nd\\_edition.pdf](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

- 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).
- 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
- 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).