Screening for and Tracking Social Determinants of Health in a Federally Qualified Health Center

An IHI Open School Quality Improvement Practicum

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Background

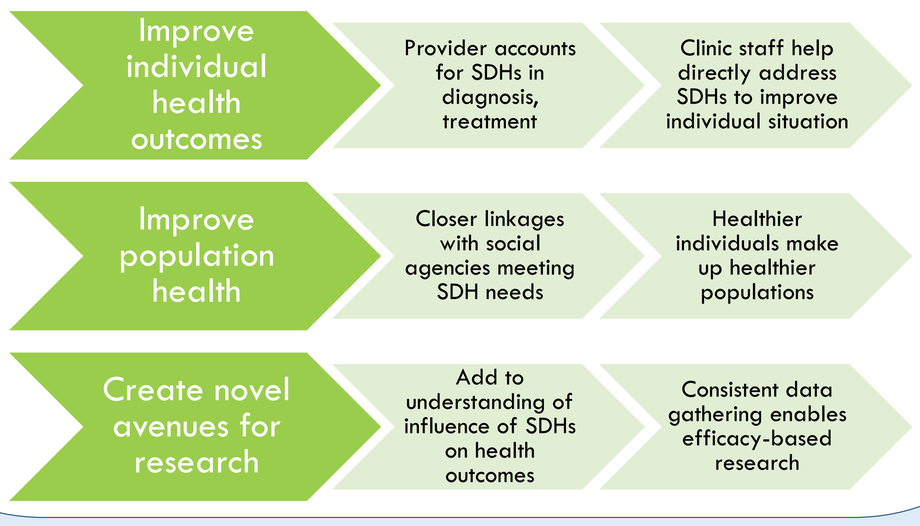
I worked with an interprofessional team at a Federally Qualified Health Center in Portland, Ore., consisting of myself (public health student), the clinic quality manager, and behavioral health providers. Our intention was to develop a way to address social determinants of health (SDHs) in their patient electronic health records (EHR).

Patients with social or economic needs such as food or housing insecurity, or unemployment or job insecurity, often have difficulty managing medications, keeping appointments, or having living conditions that support optimal health.

A baseline review of randomly selected patient charts showed inconsistency in whether SDHs were charted at all, and where they were recorded.

Standardizing documentation of SDHs will ensure that providers are gathering this information, and can reliably be aware of the social challenges each patient is facing. By helping patients address needs such as food, housing, finances and social support, we expect to improve their ability to self-manage chronic conditions.

Why should primary care address SDHs?



Aim statement (How good? For whom? By when?)

By April 30, 2015, all patients who have seen behavioral health providers in clinic will have their relevant social determinants of health (SDHs) and the provider action(s) documented in a standard electronic health record location.

Changes tested

The team tested using a dot-phrase in different locations in patients' medical records to streamline screening for and documentation of SDHs. (A dot-phrase is pre-written text that can be inserted into the patient chart with a click.)

Methodology

I utilized the complete IHI Model for Improvement to lead this project, including a project charter, Ishikawa diagram of root causes, 7 PDSA cycles, and run charts for our process and outcomes measures.

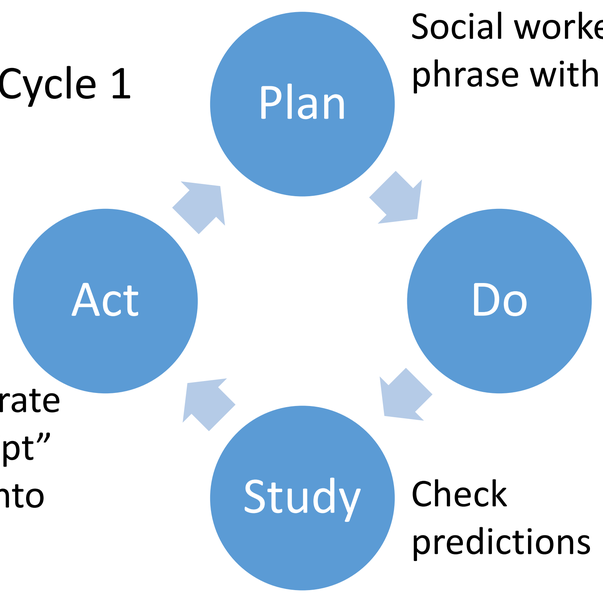
After revisions identified in cycle 1, the dot-phrase looked like this:

Draft Social Determinants of Health dot-phrase – cycle 2
[Auto-insert provider name, date of note]

Patient indicates presence of the following social determinants of health:
(Provider: Delete those that do not apply.)

Financial / Employment status and / or meaningful work Action:
Housing Action:
Years of schooling / literacy Action:
History of abuse / trauma / loss Action:
Transportation Action:
Nutrition / food security Action:
Social connections / isolation Action:

Cycle 1



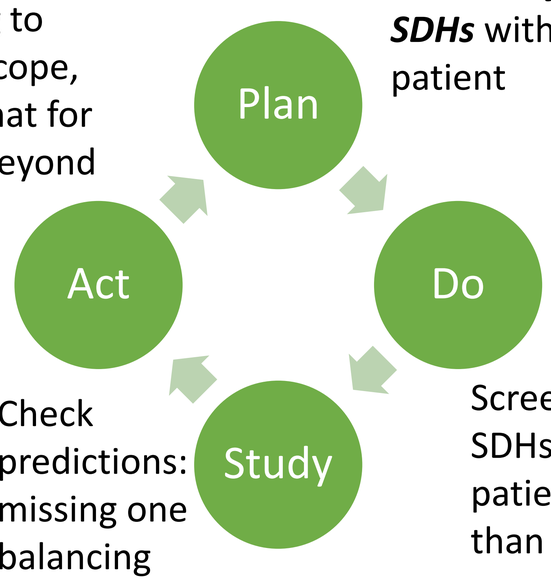
Social worker tests dot-phrase with one patient

Screened for SDHs instead of passive documentation

Check predictions

Incorporate "off-script" action into Cycle 2

Cycle 2



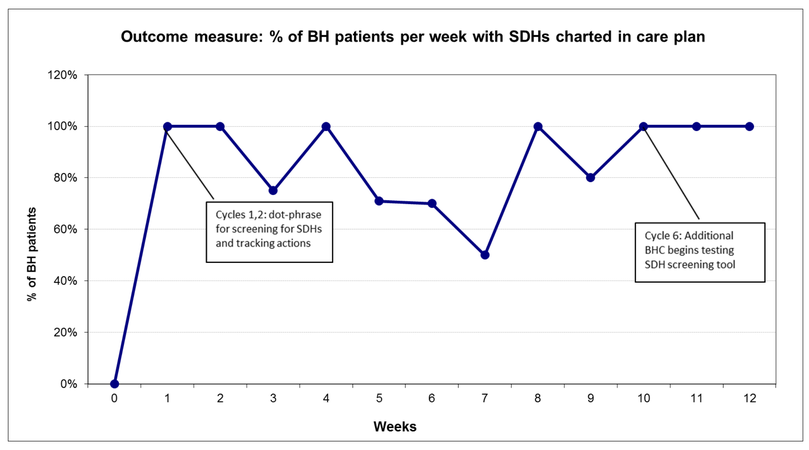
Social worker tests dot-phrase ***to screen for SDHs*** with one patient

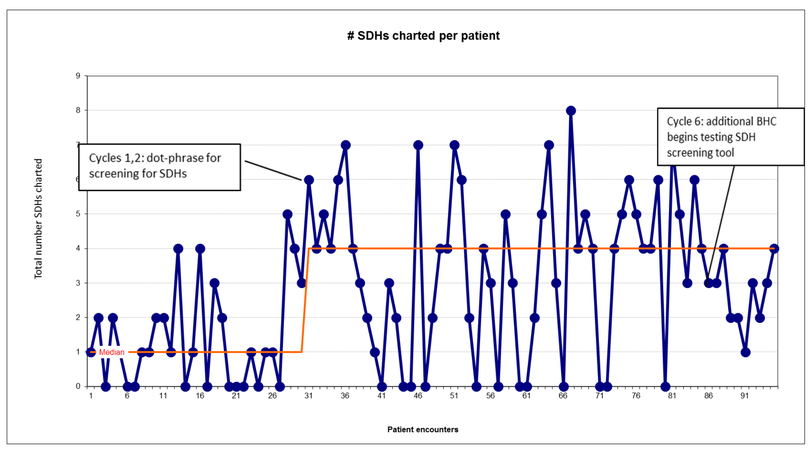
Screened for SDHs with 5 patients rather than one

Check predictions: missing one balancing measure

Team meeting to check goals, scope, feedback format for cycles 3 and beyond

Results





Learning Through this screening we have determined that despite existing resources, most of the patients at Richmond Clinic have unmet SDH needs impacting their health outcomes.

Next steps I will continue this project as my MPH internship, beginning summer 2015. Our team will 1) conduct a listening campaign with community members; and 2) create a new community health worker role at the clinic, to meet these needs.

By improving the clinic's awareness and tracking of SDHs in their population, we have paved the way for a new kind of population health intervention for this clinic, conceived and carried out outside the clinic walls by the community itself.

References:
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